could care less, but until the two managers are here—unless you have cleared it with the two managers.

Mrs. HUTCHISON. No, I have not.

The PRESIDING OFFICER. The objection is heard.

The Senator from Texas has requested the yeas and nays. Is there a sufficient second? There is a sufficient second. The yeas and nays are ordered.

Mrs. HUTCHISON. I ask unanimous consent following the vote this afternoon in relation to the Dodd amendment No. 969, the Senate vote consecutively in relation to the following amendments: Pryor amendment 981, Boxer amendment 1001; provided further that there be 2 minutes equally divided between each of the votes with no amendments in order to the amendments prior to the vote.

Mr. REID. We do not object.

Mrs. HUTCHISON. And I ask the Democratic leader work with me to be in the next series of votes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I say to the distinguished Senator from Texas we will try to do that. It seems the right thing to do.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate will now stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:32 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding Officer (Mr. VOINOVICH).

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENT NO. 969

The PRESIDING OFFICER. Under the previous order, the hour of 2:15 having arrived, there will now be 10 minutes evenly divided prior to a vote in relation to the Dodd amendment, No. 969.

Mr. DODD. Mr. President, do I need to ask unanimous consent the present amendment be temporarily set aside?

The PRESIDING OFFICER. That is unnecessary.

Mr. DODD. Mr. President, in the 5 minutes I have, let me discuss it very briefly with my colleagues.

This amendment would allow Medicare beneficiaries the freedom to move between plans for the first 2 years that this benefit is in effect, from 2006 to 2007. Under the present bill, you have to make a decision immediately and then you are locked into that decision for a year. Then you would have an open enrollment period for a month after that, and then you would be locked in for another year.

What we are offering with this amendment is initially seniors be given a 2-year window in order to decide which plan works best for them. Then you would go to the 1 year with the 1-month open enrollment. But, initially, given the tremendous amount of potential confusion about which of these various alternatives would work best for people, they ought to be given a bit more time than to have to make an almost instantaneous decision about which of these plans is best suited for them.

One of the hallmarks that has been used to describe this bill is it is to give people choice—flexibility and choice. All we are suggesting is an additional 2 years, if you will, not requiring an immediate decision but a 2-year window in order to make that choice so people are more well informed.

There are a number of areas in the underlying bill that do not go nearly far enough, in my view, to serve Medicare beneficiaries. But I believe this is a good first step, at least as presently proposed. I am inclined to be supportive of this bill. These are some small points I think could help make this a better bill.

If enacted, the underlying bill would require, as I mentioned, Medicare beneficiaries to choose a prescription drug plan and to stay with that plan for a minimum of 1 year. With the enactment of such broad and sweeping changes in the Medicare Program, I am fearful many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular needs. Beneficiaries would be faced with a menu of plans offering varying premiums, copayments or coinsurance, drug formularies, and all the other variables that make up a prescription drug benefit. It may not be immediately clear to people over the age of 65 which of these plans is going to best suit their needs. It is not difficult to imagine a scenario where this could become a significant problem, possibly even affecting the health and well-being of the beneficiary we are trying to assist with this legislation.

A senior on a tight budget might enroll in a plan in an area that offers slightly lower premiums and coinsurance. Perhaps that beneficiary is on blood pressure medication and, after enrolling in the plan, discovers the particular medication—which she has been taking for years and has proven to be effective for a condition, with minimal side effects—is not part of the formulary for the plan she chose immediately.

What I am suggesting is, What are her options? As the bill is currently written, she is stuck with that plan for at least a year. So she can try to navigate the hurdles and obstacles that would allow her to take an off-formulary drug, or switch to another drug that might not be as effective or cause severe side effects. These are not optimal choices.

One of our stated goals is to give seniors as much of a choice as possible, and I am firmly behind that goal, as I mentioned at the outset of these remarks.

I do not want to suggest for a second that we should reduce choice or create simplicity, nor do I question the importance of cost-control mechanisms such as formularies. However, with choice and differentiation comes uncertainty. I believe we can greatly relieve this uncertainty by allowing those initially choosing prescription drug plans for the very first time the opportunity to move from one plan to another to determine which of these plans offers the best plan to fit their needs, and to give them the opportunity of doing that for a 2-year period, and then go to the open enrollment period and a 1-year after that.

I asked people in my own State to take a look at this proposal. In fact, this language comes from them. Their suggestion is this language I have on this chart. I will read from it:

> The amendment which you are proposing is essential to ensure fair and informed access to the health plans which are planned under the terms of S. 1.

By the way, these people are very much supportive of what Senator GRASSLEY is doing in this bill. They say:

> Our experience with Medicare beneficiaries in Connecticut and nationally has shown that the ability of a Medicare beneficiary to change from plan to plan, especially during the period after initially choosing a plan, is of utmost importance. Making choices about which health plan is best is often confusing for a Medicare beneficiary, especially for those who are elderly, frail or having medical problems. Comparing plans and choosing the right plan can be a complicated process, and Medicare beneficiaries who discover they have not made the most informed choice, whose experience with a plan demonstrates it is not adequate to meet their needs, or who have changes in their life circumstances, need to have some ability to change from one plan to another. Only with this ability to change can they be assured the opportunity to receive the kind of health care they want, and the fullest health benefit they need, to meet their individual circumstances under the Medicare program.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. Mr. President, I ask unanimous consent for 30 additional seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DODD. All we are asking is, instead of forcing people to make that initial decision, they be given that 2-year window to sort this out. And then you move into the 1 year and the window opens, and so forth. I do not think this has any significant financial implications. It is just allowing people to make intelligent, good choices which all of us want to provide people, particularly older Americans who could be terribly confused by choosing formularies and coinsurance and copayment plans. All that has to be done at the outset once this bill becomes law.

I have used a little more time than I said I would to try to explain the amendment, but I want it to be clear to my colleagues why I think this is a

very reasonable suggestion to make an improvement to this bill.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. I thank the Presiding Officer for his indulgence.

The PRESIDING OFFICER. Who yields time?

Mr. DODD. Mr. President, I ask unanimous consent that my colleague, Senator LIEBERMAN, be added as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Who yields time?

Mr. DODD. Mr. President, if they don't want to talk, I will be glad to take a little more time to explain this amendment.

Mr. GRASSLEY. Mr. President, I will yield the man 1 minute of my time.

Mr. DODD. Mr. President, I thank the man from Iowa for yielding the 1 minute.

The PRESIDING OFFICER. The Senator is recognized for 1 minute.

Mr. DODD. The man from Connecticut appreciates the man from Iowa giving him 1 more minute.

Mr. President, very briefly, the existing underlying bill says you have to make this choice about which plan you want to go into almost immediately once this proposal becomes law. We are suggesting that at the outset you give people a 2-year window to shop wisely. They may make the decision right away. They may make it within a month or two. But knowing how confusing this can be, knowing that different formularies provide for different medications, we ought to provide people at least some opportunity to get this right to the extent they can. So this is merely opening up that window from an immediate choice to a 2-year choice—anytime within that 2 years to make that right choice.

There have been some who wondered, if you move from one plan to the next, what are the cost implications? I will be glad to respond to that. We do not think that is terribly complicated to figure out. If you have reached your deductible levels, obviously, the same would have to apply. You would not start all over in that 1-year period. So whatever costs you have incurred, whatever expenditures you have made or not made would move from one plan to the next, at least as far as the cost goes.

So the additional time should not have any additional financial or fiscal implications but merely the choice of saying to people, who are older Americans: You get a little more time to sort this out. That is all I am suggesting with this amendment.

I would hope the committee might support it. It is not a radical proposal.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. DODD. I thank the Senator.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume.

I know the Senator from Connecticut has well-intentioned motivations behind his amendment. The reason why I oppose the amendment is not because of any ill intent. But we have very carefully crafted this product before us after the Federal Employees Health Benefits Plan and the open season and the practice there. As far as I know, we do not run into Federal employees complaining because they cannot change more often than once a year. So I am going to ask my colleagues to vote against this amendment.

It has some costs. I will speak about that. The open enrollment period in S. 1, as I said, is modeled after the annual open enrollment period of the Federal Employees Health Benefits Plan. I believe this program has been in place for more than 40 years, so we have a lot of experience with it. Consequently, it is a good pattern for us to craft the legislation before us for senior citizens in retirement for their health benefits.

Each year seniors would be able to examine the choice of plans and select the plan that is best suited to their needs. The amendment before us proposes to allow seniors to change plans more than once during a continuous open enrollment period that would last for 2 years. While this may seem a good idea on the surface, it is an invitation, I believe, to more expensive health care for our seniors. I think it is going to lead to chaos and plan instability.

It is very important, at least in the opening years, as we get these new programs underway that there be some predictability in order to encourage more plans to compete. The more plans competing, the better benefits we ought to get for our seniors at a lower price.

It seems to me that providing a long, continuous open enrollment period allows any and all seniors to wait until they are sick before enrolling in a more comprehensive plan. You can understand that we need to have a situation where people are seen buying insurance and doing it in a way in which they manage their own risk as opposed to doing it in the case of only an emergency. This is where you get the insurance aspect that is so important in what we are trying to accomplish.

So if you do that, as the Senator from Connecticut suggests, it is going to add costs to the program because it permits healthy enrollees to stay in the cheaper basic plan until an illness drives them to a generous plan. The generous plan then would become the plan just for sick enrollees.

I have a statement here that the CBO says this would have a cost of $8 billion over the years 2004 to 2008, and $23 billion for the 10-year period 2004 to 2013.

I am going to yield back the remainder of my time.

The PRESIDING OFFICER. All time has expired.

Mr. DODD. I ask unanimous consent for an additional 30 seconds.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DODD. Mr. President, this is one time. Unlike Federal employees, who are 30 or 35 years of age, this plan is all new. What we are saying is, for the very first 2 years—that is all, just the first 2 years—give seniors the flexibility so they do not have to sign up for a plan immediately. You get a couple years within that timeframe to make your choice, then you go into the 1-year cycle as all the rest of us do. But for older Americans, it is very confusing—very confusing—for them to have to make that choice at the get-go, right at the very beginning. So that 2-year window, to have some flexibility to make a choice that best serves your interest, I think is a reasonable request to make for our older Americans. That is the end of it.

Mr. GRASSLEY. Mr. President, I ask unanimous consent for an equal 30 seconds.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I have some sympathy for what the Senator from Connecticut says because so many times I have said to my constituents, this is voluntary. You are going to have your choice to go into another plan or change plans. I emphasize the ability to change plans. In addition, we have to have some stability even in the early years. Most importantly, when we are developing a new prescription drug benefit, the most vast improvement in Medicare in 35 years, I think it demands more stability than when you get down the road a ways.

I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion to table amendment No. 969. The clerk will call the roll.

The bill clerk called the roll.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LEIBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 55, nays 42, as follows:

[Rollcall Vote No. 234 Leg.]

YEAS—55

Alexander	Chambliss	Fitzgerald
Allard	Cochran	Frist
Allen	Coleman	Graham (SC)
Baucus	Collins	Grassley
Bennett	Cornyn	Gregg
Bond	Craig	Hagel
Breaux	Crapo	Hatch
Brownback	DeWine	Hutchison
Bunning	Dole	Inhofe
Burns	Domenici	Jeffords
Campbell	Ensign	Kyl
Chafee	Enzi	Lott

Lugar	Santorum	Sununu
McCain	Sessions	Talent
McConnell	Shelby	Thomas
Murkowski	Smith	Voinovich
Nelson (NE)	Snowe	Warner
Nickles	Specter	
Roberts	Stevens	

NAYS—42

Akaka	Dorgan	Levin
Bayh	Durbin	Lincoln
Biden	Edwards	Mikulski
Bingaman	Feingold	Miller
Boxer	Feinstein	Murray
Byrd	Harkin	Nelson (FL)
Cantwell	Hollings	Pryor
Carper	Inouye	Reed
Clinton	Johnson	Reid
Conrad	Kennedy	Rockefeller
Corzine	Kohl	Sarbanes
Daschle	Landrieu	Schumer
Dayton	Lautenberg	Stabenow
Dodd	Leahy	Wyden

NOT VOTING—3

Graham (FL)	Kerry	Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. SANTORUM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the remaining two votes in this series be limited to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 981

The PRESIDING OFFICER. Who yields time on the Pryor amendment?

The Senator from Arkansas.

Mr. PRYOR. I thank the Chair.

Mr. President, the United States may be the only country in the world that does not protect its population from price gouging when it comes to prescription drugs. Last week, the Senate took a very important step in eliminating that by adopting the Dorgan-Cochran amendment by a vote of 62 to 28 to allow the reimportation of prescription drugs from Canada.

This amendment gives that amendment teeth. It gives HHS 2 years to act, and if they do not act within 2 years, then it becomes illegal for prescription drug companies to sell their products in the United States for more than they sell them in Canada.

Some people call this price control. I respectfully disagree, but if you call it price control, that means 62 of us last Friday stood up for price controls. What it does in reality is introduce competition on prices.

There is one drug called tamoxifen. Tamoxifen is a fantastic breast cancer drug. One could buy it before it became generic for $241 for 60 pills in the United States, and for $34 for 60 pills in Canada. The difference between $241 and $34 is very significant, and that is what we are trying to fix.

I thank the Chair.

Mr. SANTORUM. Mr. President, I hope my colleagues can hear me. What the Pryor amendment does has nothing to do with reimportation. What it says is, if the Secretary does not certify that the drugs are safe coming from Canada after 2 years, we will adopt the Canadian pricing scheme for pharmaceutical products in this country. So the Government of Canada will set prices for pharmaceutical drugs in this country. We will be ceding to the Government of Canada the right to set prices for drugs in the United States of America.

If we want to have price controls for drugs, we should have a debate to do that, but we should not be ceding to a foreign government the right to set drug prices in this country, and that is what this amendment does.

Whether you are for reimportation, whether you are for price controls for drugs, do not give up the right to set the price controls to a foreign government who will set them for the United States. And that is what this amendment does. I urge an overwhelming negative vote.

The PRESIDING OFFICER (Mr. CRAPO). The question is on agreeing to the amendment.

Mr. REID. The yeas and nays are not in order.

Mr. SANTORUM. I move to table the amendment and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The PRESIDING OFFICER. The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 66, nays 31, as follows:

[Rollcall Vote No. 235 Leg.]

YEAS—66

Alexander	Craig	Lugar
Allard	Crapo	McCain
Allen	DeWine	McConnell
Baucus	Dodd	Mikulski
Bayh	Dole	Murkowski
Bennett	Domenici	Murray
Biden	Ensign	Nelson (NE)
Bingaman	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Santorum
Brownback	Graham (SC)	Sessions
Bunning	Grassley	Shelby
Burns	Gregg	Smith
Campbell	Hagel	Snowe
Carper	Hatch	Specter
Chafee	Hollings	Stevens
Chambliss	Hutchison	Sununu
Cochran	Inhofe	Talent
Coleman	Jeffords	Thomas
Collins	Kyl	Voinovich
Cornyn	Landrieu	Warner
Corzine	Lott	Wyden

NAYS—31

Akaka	Feingold	Miller
Boxer	Feinstein	Nelson (FL)
Byrd	Harkin	Pryor
Cantwell	Inouye	Reed
Clinton	Johnson	Reid
Conrad	Kennedy	Rockefeller
Daschle	Kohl	Sarbanes
Dayton	Lautenberg	Schumer
Dorgan	Leahy	Stabenow
Durbin	Levin	
Edwards	Lincoln	

NOT VOTING—3

Graham (FL)	Kerry	Lieberman

The motion was agreed to.

AMENDMENT NO. 1001

The PRESIDING OFFICER. There are 2 minutes equally divided for consideration of the Boxer amendment.

Mrs. BOXER. Mr. President, I would like to explain in 1 minute a very important amendment that will really improve this bill. This amendment is endorsed by the AARP—they feel very strongly about it—in addition to the other major seniors organizations to preserve Social Security and Medicare. In the bill right now, there is a benefit shutdown when you reach $4,500 worth of purchased drugs. That means seniors will face a $1,300 deficit before they start getting the benefit. I will just implore my colleagues, there is not any other prescription drug plan in this country that does this. This is a really terrible problem for our people. Just when they need help the most, they stop getting help.

I conclude, since we have so little time, by reading what AARP says:

> AARP members find the notion of a gap in coverage to be a major barrier to enrolling in a Medicare drug benefit. They tell us that they are unaware of similar features in any of the insurance products they routinely purchase.

In closing, they say:

> . . . we urge the Senate to eliminate this coverage gap.

Please make this bill better, friends. It is the least we can do for seniors.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I rise in opposition to make four points.

First, we had an additional $30 billion when this bill was originally marked up in the Finance Committee. We put all $30 billion into filling the donut, so we have done as much as we can with the money allocated.

Second, this amendment costs $64 billion. We would bust the agreement, which is to stay within the budget of $400 billion.

Third, according to CMS, only 2 to 12 percent—depending on your estimates—are going to be affected by this ''coverage gap.''

Finally, there is no standard benefit. This is sort of a mystery I don't know why we don't talk about more. This is a typical design of what a benefit would look like. But under this bill, the companies bidding on these pharmaceutical contracts can design the benefit any way they want. They can have a donut. They do not have to have

a donut. The only thing they are required to do is have a $275 deductible for those plans of 160 percent of poverty and above and have $3,700 in total spending before the catastrophic kicks in. The donut is illusory, and I ask my colleagues to vote no on the amendment.

Ms. MIKULSKI. Mr. President, I rise today in strong support of the amendment No. 1001 offered by my colleague from California, Senator BOXER.

The Senate is debating legislation to provide seniors with prescription drugs that is a start but there are also many shortcomings with this bill. One of most glaring shortcomings is the gap in drug coverage. It doesn't make sense. As drug costs rise, benefits get shut off and seniors with high drug costs have to pay all of their drug costs from $4,500 to $5,800. I think that is cruel.

How would this amendment address this shortcoming?

It is simple. This amendment would let seniors continue to have continuous coverage until you hit the catastrophic cap of $5,800 so that means no gap. And, then your copay would drop to 10 percent just like in the bill. No figuring out when you hit the coverage gap. No figuring out how long you are going to be in the hole. No paying premiums and not getting benefits. You simply get drug coverage.

Why is this amendment important?

The coverage gap imposes a ''sickness tax'' on seniors. Once drug spending reaches $4,500 and this is a senior who clearly is facing serious health problems this senior would now have to pay $1,300 of their own money without any help from the Government even though they are still paying premiums to stay in the plan.

What does this mean?

Millions of our seniors will have no drug coverage for several months out the year. Their coverage will just stop and for many; it may not start back up again until the next year.

This is wrong. I believe honor thy mother and father is not just a good commandment to live by, it is good public policy to govern by. That is why I feel so strongly about Medicare. Congress created Medicare to provide a safety net for seniors. I don't think there should be any holes in that net. That is why I support this amendment and urge my colleagues to also.

The PRESIDING OFFICER. The Senator's time has expired.

The yeas and nays have been previously ordered on this amendment.

Mr. SANTORUM. Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion to table amendment No. 1001.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''nay''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 54, nays 42, as follows:

[Rollcall Vote No. 236 Leg.]

YEAS—54

Alexander	DeWine	McCain
Allard	Dole	McConnell
Allen	Domenici	Miller
Baucus	Ensign	Murkowski
Bennett	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Santorum
Brownback	Graham (SC)	Sessions
Bunning	Grassley	Shelby
Burns	Gregg	Smith
Chafee	Hagel	Snowe
Chambliss	Hatch	Specter
Cochran	Hutchison	Stevens
Coleman	Inhofe	Sununu
Collins	Jeffords	Talent
Cornyn	Kyl	Thomas
Craig	Lott	Voinovich
Crapo	Lugar	Warner

NAYS—42

Akaka	Dorgan	Levin
Bayh	Durbin	Lincoln
Biden	Edwards	Mikulski
Bingaman	Feingold	Murray
Boxer	Feinstein	Nelson (FL)
Byrd	Harkin	Nelson (NE)
Cantwell	Hollings	Pryor
Carper	Inouye	Reed
Clinton	Johnson	Reid
Conrad	Kennedy	Rockefeller
Corzine	Kohl	Sarbanes
Daschle	Landrieu	Schumer
Dayton	Lautenberg	Stabenow
Dodd	Leahy	Wyden

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be laid aside so that the Senator from New Jersey may offer an amendment.

The PRESIDING OFFICER. Is there objection?

Mr. SESSIONS. Reserving the right to object, is the Senator going to speak? I could not hear.

Mr. BAUCUS. I withdraw the request. I ask unanimous consent that there be 30 minutes equally divided on the Lautenberg amendment and, immediately following that debate, the Senate vote on the Lautenberg amendment.

Mr. SESSIONS. Reserving the right to object, I just want to call up an amendment and set it aside. Will the Senator agree we can do that?

Mr. LAUTENBERG. I did not hear the request. Was the Senator asking a question of me?

Mr. SESSIONS. Mr. President, I was asking unanimous consent that I be allowed to call up an amendment for 30 seconds and set it aside before the Senator from New Jersey commences his remarks.

The PRESIDING OFFICER. The Senator from Montana has the floor.

Mr. BAUCUS. I yield the floor and withdraw my request.

The PRESIDING OFFICER. The Senator from Alabama may state his request.

AMENDMENT NO. 1011

Mr. SESSIONS. Mr. President, I call up amendment No. 1011.

The PRESIDING OFFICER. The Chair will interpret the Senator's request as a unanimous consent request to set aside all pending amendments. Is there objection to setting aside all pending amendments?

Without objection, it is so ordered. The clerk will report.

The legislative clerk read as follows:

The Senator from Alabama [Mr. SESSIONS] proposes an amendment numbered 1011.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under medicaid and SCHIP as part of the reauthorization of the temporary assistance for needy families program)

Strike section 605 and insert the following:

SEC. 605. SENSE OF THE SENATE REGARDING HEALTH INSURANCE COVERAGE OF LEGAL IMMIGRANTS UNDER MEDICAID AND SCHIP.

(a) FINDINGS.—The Senate makes the following findings:

(1) In 1996, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105)(commonly referred to as the ''welfare reform Act''), Congress deliberately limited the Federal public benefits available to legal immigrants.

(2) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allows a State the option of electing to offer permanent resident legal aliens that have been living in the United States for at least 5 years the same benefits that their State citizens receive under the temporary assistance for needy families program (commonly referred to as ''TANF'') and the medicaid program.

(3) As of the date of enactment of this Act, 22 States have elected to give the permanent resident legal aliens who reside in their States the same TANF and medicaid benefits as the States provide to the citizens of their States.

(4) This Act, the Prescription Drug and Medicare Improvement Act of 2003, is not a welfare or medicaid reform bill, but rather is a package of improvements for the medicare program that is designed to provide greater access to health care for America's seniors.

(5) The section heading for 605 of this Act as reported out of the Committee on Finance, was titled ''Assistance with Coverage of Legal Immigrants under the medicaid program and SCHIP,'' and, as reported, related directly to the provision of benefits under

the medicaid and State children's health insurance programs, not to benefits provided under the medicare program.

(6) The reported version of section 605 would have directly overturned the reforms made in the 1996 welfare reform Act.

(7) The reported version of section 605 would have greatly expanded the number of individuals who could receive benefits under medicaid and SCHIP.

(8) No hearings have been held in the Committee on Finance of the Senate concerning why the 5-year residency requirement for legal aliens to obtain a Federal public benefit established in the welfare reform Act needs to be overturned or why the reported version of section 605 should be included in a medicare reform package.

(9) Congress must reauthorize the temporary assistance for needy families program later this year and should hold hearings regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit should be overturned as part of the reauthorization of that program.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Committee on Finance of the Senate should hold hearings in connection with the reauthorization of the temporary assistance for needy families program, or in connection with reform of the medicaid program, regarding whether the 5-year residency requirement for legal aliens to obtain a Federal public benefit that was established in the 1996 welfare reform Act should be overturned for purposes of the medicaid and State children's health insurance programs.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the amendment be set aside for consideration at the appropriate time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. Mr. President, I want to be certain of the order. My amendment is at the desk. What I want to do is in the time allocated to me—which I understand is 15 minutes per side; is that correct?

The PRESIDING OFFICER. At this point, no such order has been entered.

Mr. LAUTENBERG. I thank the Chair.

AMENDMENT NO. 982

Mr. LAUTENBERG. Mr. President, I call up my amendment which is at the desk.

The PRESIDING OFFICER. Without objection, the pending amendments will be set aside. The clerk will report.

The legislative clerk read as follows:

The Senator from New Jersey [Mr. LAUTENBERG], for himself, Mr. REED, Mr. REID, Mrs. CLINTON, and Mr. CORZINE, proposes an amendment numbered 982.

Mr. LAUTENBERG. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To make prescription drug coverage available beginning on July 1, 2004)

At the end of title I, insert the following:

SEC. ___. IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under part D of title XVIII beginning on July 1, 2004.

Mr. LAUTENBERG. Mr. President, I rise to talk about my amendment which is designed to change the effective date of this bill.

My amendment is cosponsored by Senators REED of Rhode Island, REID of Nevada, CLINTON, and CORZINE.

My amendment is very simple: Let's give our seniors a prescription drug benefit just as quickly as we can. They need it now. Let's not delay any longer than practicable to get it into place.

Under the current proposal, comprehensive drug coverage does not start until July 2006. Imagine that, 2006. It is not fair to seniors who are expecting a benefit almost immediately. They will have seen President Bush sign a bill with some fanfare and will have seen lots of Members of Congress crowding the stage with him, and everyone will say: We have put a prescription drug benefit into place. When seniors learn that the benefit begins in 2006, they are going to feel deceived, tricked, and angry.

My amendment changes the effective date of the coverage to July 1, 2004. There is not any reason to have our seniors wait any longer for a prescription drug benefit.

The original Medicare plan was signed into law by President Johnson on July 30, 1965, and 11 months later, July 1, 1966, all persons eligible were enrolled. The entire system for Medicare was created in just 11 months.

When we look at this chart, we see what is planned with the Bush/Senate prescription drug benefit. We are looking at 30 months, and we are looking at the creation of an entire Medicare system which took just 11 months to put in place. That was done without the luxury of today's high-speed computers. It was just President Johnson and his administration getting the entire system in place in 11 months.

My amendment essentially follows the same timetable. If President Johnson was able to create the entire Medicare system in just 11 months, then surely President Bush should be able to add a drug benefit in the same amount of time.

Look at the timeline the President has set for this Medicare drug proposal: 30 months. Why so long? Our clue is, what? Election day. That is illustrated on this chart. Sixteen months from now, this prolonged effective date is conveniently well past election day.

The administration's Medicare agency, CMS, says it needs 30 months. That is very convenient timing for political purposes, but it is terrible timing for America's seniors.

President Johnson, a true Texan, had a can-do attitude, and there is no reason this administration cannot dedicate itself to completing this task in 11 months. We need to give seniors meaningful drug coverage as soon as possible, not 2006.

The reality is that 5.5 million seniors currently on Medicare will not be alive in 2006. If there are insufficient funds in the budget for this amendment, then it is the result of choices made by the President and his party. They chose to provide a massive tax cut to the wealthiest among us, and they chose it at the price of Medicare.

The issue is simple: If we give a prescription drug benefit, why would we want to withhold it? This bill is about fooling the American people about the mission here. It is more about elections than correcting the problems associated with a prescription drug program. I urge my colleagues to support this amendment.

Mr. President, we have some time remaining. How much time remains on our side?

The PRESIDING OFFICER. There is no set amount of time. The Senator has consumed 5 minutes.

Mr. LAUTENBERG. Mr. President, I yield the floor. I know the Senator from Nevada is interested in speaking.

Mr. GRASSLEY. Mr. President, I yield myself such time as I may consume in opposition to the Lautenberg amendment.

The PRESIDING OFFICER. The Senator has the floor.

Mr. GRASSLEY. Maybe I should ask, are we under time constraints?

The PRESIDING OFFICER. There are no time constraints.

Mr. GRASSLEY. What the Senator from New Jersey wants to do I wish we could do. I personally was somewhat astounded when we asked experts at the Congressional Budget Office, experts at the Office of Management and Budget, experts in the Department of Health and Human Services, how much time it would take to get this new prescription drug program underway. We were advised to start it in the year 2006.

In an ideal world, all seniors would have access to our comprehensive prescription drug benefit next year. But our plan, I am sorry to say, cannot go into effect until 2006. Therefore, we need to do something to help our seniors right now. Part of S. 1 does that. They have been doing it because seniors, as I am sure the Senator from New Jersey is trying to respond to, have been waiting a very long time for Congress to act and pass a prescription drug benefit, in the end, helping them with the tremendous costs they are paying for prescription drugs.

This obviously is not satisfying to the Senator from New Jersey who would like to get this plan underway much sooner. Because of the waiting period until the year 2006 to get the very comprehensive program underway, we included in our plan a temporary prescription drug discount card. This is a voluntary program that all seniors can partake of next year. It is available for an annual fee costing no more than $25. Since our low-income seniors need extra help, this fee would be waived. It provides for a 10-percent

to 25-percent discount on all costs of prescription drugs. There are some seniors for whom even a 10-percent to 25-percent discount is still a hardship to purchase prescription drugs. So we have added to this for really low-income seniors to receive a $600 annual help in purchasing prescription drugs during this interim period of time, 2004 and 2005. They will be required to pay a minimal copayment of 10 percent when the spending of the $600 subsidy is in place. Spouses who receive the low-income benefit are also allowed to pool share their deposits.

When the comprehensive drug program begins January 1, 2006, the discount card program automatically ends. However, low-income seniors will be able to use their allotment of $600 until June 2006.

Almost 10 million Medicare beneficiaries with significant prescription drug needs will realize savings from this endorsement program. The Center for Medicare Services projects that the Medicare beneficiaries will save between $1.2 billion and $1.6 billion in the program the very first year.

As I said, I feel, not for reasons I like to give to my fellow Senators, that we cannot expect this comprehensive new prescription drug program for seniors, which happens to be the first major improvement in strengthening of Medicare since 1965, to go into effect. Maybe we can push and push and push, but this first major expansion of Medicare in 38 years ought to be carefully done and done right. Consequently, that is why we have deferred to the judgment of the Congressional Budget Office, Office of Management and Budget, as well as the Secretary of HHS. We have tried to compensate for the long period of phasing with the discount card and the $600 subsidy.

I wish I could do more. I wish I could vote for the Senator's amendment but I cannot. I ask my colleagues to vote against it.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Jersey.

Mr. LAUTENBERG. I say to our friend from Iowa, the discount card allows somewhere between 10 and up to 25 percent. With seniors spending an average $2,300 a year on medication, even a 20-percent discount does not provide nearly enough relief. Frankly, it is hard to understand why it has to take 2½ years to get the program into place. I rather suspect it has less to do with the perfection of the program than it has to do with some other cause. It cannot take that long. We have all of these seniors on record. They are medical enrollees now. Why can't we get this going?

As a matter of fact, my colleague from Minnesota, who is going to say something, thinks it should be done in an even shorter period of time than my amendment provides.

I ask my colleague if he would like to say something. I yield the floor.

The PRESIDING OFFICER. The Senator from Minnesota.

Mr. DAYTON. Mr. President, I join with my Senator from New Jersey. He persuaded me to be reasonable. This is the reasonable alternative proposal, July 1 of 2004. I have great respect for the chairman of the Senate Finance Committee, the Senator from Iowa. I sense his difficulty because I don't believe the senior citizens of anywhere else in America will be any different from the senior citizens of Minnesota who will be, I believe, absolutely beside themselves to learn this program they have waited years for Congress to enact will be enacted but it will not be ready for 2½ years.

I suggest perhaps one of the reasons is that this is not a system that can be easily put in place or administered. The chairman is trying to accommodate, if I understand his remarks correctly, the administration, the Office of Management and Budget, and the Secretary of Health and Human Services. They said this program as designed cannot be put together and administered and operational until January 1, 2006.

I suggest that is pretty strong evidence that is not a very good system for delivery of these services. We have insurance companies that are going to be providing policies—they are in the business of providing insurance for people. It can't take them 2½ years to design this program. Regarding CMS or HHS, the Department itself, we hear from this administration how their management of Government is so much improved over their predecessor's. Is it going to take them 2½ years to design this program when, as my colleague from New Jersey, Senator LAUTENBERG, pointed out, 40 years ago they were able to take the whole Medicare Program and put that in effect in 11 months?

Not only do I support the amendment offered by Senator LAUTENBERG, but I have to say for those who are advocating this as the preferred alternative to extending Medicare to cover prescription drugs, if they cannot get the program up and running in a lot less than 2½ years—either 6 months as I would propose, or a year—then this is the wrong program because this is not a viable alternative, and it is not viable for the senior citizens of Minnesota or anywhere else, in my judgment.

To say people are going to get a discount card—they can get discount cards already. They don't need Congress to do anything more than that for 2½ years.

Just taking the figure the Senator from Iowa offered, if I understand it correctly, of savings for seniors in America, Medicare beneficiaries, of $1.26 billion the first year, it sounds like a lot of money—it is a lot of money—but there are 40 million Medicare beneficiaries in the country. If you divide $1.26 billion in savings by those 40 million, that is about $30 per Medicare beneficiary in the first year.

We are going to go back with this to the senior citizens of Minnesota, and those with disabilities who are being crushed by these prices, who see them going up all the time due to the greed and profiteering of the pharmaceutical industry. We are told here we have a bill, because it is the only one the majority of the Senate will agree to, that is not going to do anything—nothing at all, under our Government, on behalf of seniors and on behalf of all American consumers of prescription drugs, to bring these prices down. Instead, they are going to get a discount card that is going to save them on average $30 a year? We ought to be ashamed of ourselves, first of all. This bill is not what it is purporting to be, which is real relief for anybody who needs it now, not January 1, 2006.

If my colleagues do not support this, I think we are sending a very strong message to America that this is not a viable program to begin with, and the pharmaceutical industry has, one more time, succeeded in putting their profits ahead of the needs of people in America.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. I know the Senator from New Hampshire would like to go ahead. I will speak for just a minute or 2 before he does.

I very much agree with the Senator. It seems absurd that we have to wait until 2006 before this program goes into effect. I very much understand the concern of the Senator.

Let me say this to all of us who are concerned. Before the conference report comes back, I am going to do my level best by pushing the CBO and CMS, asking a lot of tough questions of these agencies, to see if there is some way we can get this put together earlier. It is my hope we could bring back a conference report that has an earlier date, significantly earlier date. My guess is the private sector could get this done pretty quickly. It would not take a full 2 years to get it done.

I just pledge to my colleagues, this is one Senator who is going to do his level best to try to get an earlier date. The current date just doesn't make sense. We need to ask some tough questions and get some answers.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. If the Senator from New Hampshire will just give me a minute, I have a unanimous consent request on votes coming up I would like to propound.

I ask unanimous consent that at 4:20 the Senate proceed to a vote in relation to Dayton amendment No. 957, to be followed by a vote in relation to the Lincoln amendment, No. 1002; to be followed by a vote in relation to the Lautenberg amendment, No. 982, with 2 minutes equally divided for debate for each succeeding vote after the first; further, that no amendments be in order to the amendments prior to the votes; and finally that the second and

third votes be limited to 10 minutes in length.

I ask unanimous consent that prior to the first vote, Senator SUNUNU be recognized for up to 5 minutes in order to offer an amendment.

Mr. REID. Reserving the right to object, I ask the vote occur at 4:25 and I be given 5 minutes after Senator SUNUNU.

Mr. GRASSLEY. I modify my unanimous consent request accordingly.

The PRESIDING OFFICER. Is there objection?

Mr. DAYTON. Reserving the right to object, I ask the Senator, in terms of the motion, that 2 minutes be evenly divided for my amendment, the first amendment. Is there something different for that?

Mr. GRASSLEY. You would have 1 minute and I would have 1 minute.

Mr. DAYTON. I object to that. I was told by the Senator's staff I would have 2 minutes, 4 minutes equally divided.

Mr. REID. He can take a minute of my time.

Mr. GRASSLEY. You will get 2 minutes, one from your leader. Can we go ahead?

Mr. DAYTON. I have no objection.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from New Hampshire.

AMENDMENT NO. 1010

(Purpose: To improve outpatient vision services under part B of the medicare program.)

Mr. SUNUNU. Mr. President, I ask unanimous consent that all pending amendments be set aside for purposes of offering an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SUNUNU. Mr. President, I have an amendment at the desk. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Hampshire [Mr. SUNUNU] proposes an amendment numbered 1010.

Mr. SUNUNU. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The amendment is printed in today's RECORD under ''Text of Amendments.'')

Mr. SUNUNU. Mr. President, I rise to offer an amendment that effectively mirrors a piece of legislation I introduced earlier this year. This amendment will extend benefits under Medicare for vision rehabilitative services; that is, rehabilitative services for those seniors with a vision impairment.

As we debate this important prescription drug legislation, I think one of the cornerstones, one of the principles that is at stake is the objective of giving seniors more options and more choices for their health care and, in doing so, to create an option for a more holistic approach to their health care that perhaps focuses, to a greater extent, on preventive measures and other services that improve independence and improve a senior's quality of life.

This legislation is very much in keeping with that objective and that goal. This will extend coverage for vision rehabilitative services under Medicare, but it does this under the existing physician fee schedule. It does it without creating a new provider network or a new fee schedule. As a result, the cost of this legislation is estimated, over a 5-year period, to be just $8 million. That was an independent estimate that has been done. Of course, I will seek scoring under the Congressional Budget Office for the purpose of this bill.

It is legislation and a set of services that is geared toward improving the level of independence and quality of life for those seniors who are affected by a vision impairment. For the sake of reference, there are over 3.5 million Americans who are affected by vision impairment in the United States. That means vision loss that cannot be treated with eye glasses, that cannot be treated with surgery or other techniques. These seniors need help in learning how to navigate in their own homes, how to deal with the obstacles of daily life, and how to learn to live and work with that vision impairment.

The cost of vision impairment to America and to our seniors can be huge. The CDC estimates over $20 billion in costs annually due to falls and due to injuries that have occurred as a result of vision loss. Hip fractures alone, due to vision loss, are estimated to cost our country over $2 billion per year.

For those reasons, I envision under this legislation cost savings in the long term to be quite significant for the modest cost of improving coverage for these vision rehabilitative services.

This is a piece of legislation I introduced earlier this year for which I was pleased to receive bipartisan support. We have 14 cosponsors—seven Republicans, seven Democrats—and among them a number of the members of the Finance Committee.

I certainly believe this takes the right approach toward strengthening Medicare in a way that gives more focus to the kind of preventive care and the kind of medical maintenance that improves the independence and quality of life for our seniors.

I urge my colleagues to support the amendment.

I yield the floor.

The PRESIDING OFFICER. The Democratic whip is recognized.

Mr. REID. Mr. President, under the consent we obtained, I was to have 5 minutes to speak. I would ask that 1 minute of that time be given to Senator DAYTON, so he can have his 2 minutes. I ask the Chair to notify me when I have used 3 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 982

Mr. REID. Mr. President, my first elective job was when Medicare came into being. I was the chairman of the board of trustees at a place called Southern Nevada Memorial Hospital. It is now called the University Medical Center. At that time it was the largest medical facility, hospital facility in Nevada.

At that time 40 percent of the seniors who came into that hospital had no insurance, and children, other relatives, and friends had to sign a piece of paper before they came into the hospital that they would be responsible for the bills. Medicare changed all that.

In 1965, when Medicare was created by Congress, it took 11 months after the bill was signed to put a new program in place. That was back in the days of slide rules and adding machines. That was, of course, before we had computers that had any ability to function.

Today our senior citizens need help with soaring drug prices. They deserve the security of knowing they will be able to buy the medicines that can keep them alive and healthy.

So today if we are telling our seniors to wait for that help and that security until the year 2006, I do not think they are going to accept that. It will be too late for millions of seniors, people who have worked hard all their lives to make this the greatest and richest country in the world—the only superpower left in the world. Certainly, if that, in fact, is the case, we should have a prescription drug benefit for senior citizens.

It might be too late for Alice and Frederick Williams of Reno. They worked hard all their lives and raised four children. But Alice contracted hepatitis C from a blood transfusion. Today she is also battling heart disease and a thyroid condition, and Frederick is recovering from prostate cancer. Together, they have to spend $350 every month on prescription drugs. That is $4,200 a year. They don't have it.

Jackie Ridley, it might be too late for her. She is a retired teacher, who spoke at a Committee on Aging hearing in Las Vegas. She and her husband had all kinds of problems: heart disease, high blood pressure, diabetes, and emphysema. Between them, they had 25 prescriptions. Before Jackie's husband passed away, they faced out-of-pocket expenses of more than $1,000 every month. And sometimes, to make it to the next month, they cut back on some of their medicine. We have heard that before.

These Nevada seniors, and millions more like them in every single State, need help now, not 3 years from now. They deserve security now, not in 2006. That is why I rise to support the Lautenberg amendment. It would make this prescription drug benefit effective sooner rather than later.

The bill is confusing enough without asking some senior citizens to apply for one benefit now, and then come

back in 2 years to apply again. Our seniors have enough to worry about without wondering if they will be ruined financially before the benefit takes effect.

The American people know that when Congress really wants to get things done, we can take action quickly. Now they are looking for us to help them, seniors who have worked hard to make this country strong and prosperous.

I urge the support of the Lautenberg amendment.

I yield back whatever time I have.

The PRESIDING OFFICER. The Senator has used 3 minutes.

Mr. REID. I yield back.

The PRESIDING OFFICER. The Senator from Minnesota.

AMENDMENT NO. 957

Mr. DAYTON. Mr. President, I understand, under the previous order, I have 2 minutes.

The PRESIDING OFFICER. The Senator has 2 minutes.

Mr. DAYTON. Mr. President, I call up amendment No. 957 and ask the clerk to report it.

The PRESIDING OFFICER. The amendment is pending.

Mr. DAYTON. Thank you, Mr. President. I will proceed.

Mr. President, this amendment is a matter of simple fairness. It says that whatever prescription drug coverage we in Congress vote for for senior citizens and other Medicare beneficiaries in this legislation, then the Members of Congress will get for ourselves, our coverage, under prescription drugs for the life of this particular legislation.

I have heard many of my colleagues say we want to give seniors coverage that is as good as we get ourselves. I heard a lot of senior citizens in Minnesota say they want coverage as good as Members of Congress get for themselves. Well, unfortunately, the bill that is before us this week is not even close to that parity.

If you calculate the total benefits provided, the value of this bill is about half of what Members of Congress get, what we pay as part of the Federal Employees Health Benefits Plan system. But, nevertheless, it is about twice as good as what the seniors of America and those with disabilities and others are going to be able to obtain from what we are likely to pass.

Furthermore, as we have been discussing earlier, this does not even begin until January of 2006. Medicare beneficiaries will get a discount card instead. Well, then, Members of Congress should get a discount card—and nothing more—as well. I think after what I heard the Senator from Iowa say, I would include a few members of the administration since they are the culprits in this delay, but I will save that for another time. With the premiums, deductibles, and the absence of any coverage at all from $4,500 to $5,800, if it is good enough for the seniors of America, then it is good enough for the Members of Congress.

I point out to my colleagues who would like to keep the benefit level they have today——

The PRESIDING OFFICER. The Senator has used 2 minutes.

Mr. DAYTON. Mr. President, I ask unanimous consent for 30 seconds to conclude my remarks.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. DAYTON. The amendment Senator DURBIN has offered, which we will have a chance to vote on and discuss later this week, would provide seniors with a comparable package to what we have in Congress. So I urge the support of that amendment, for that reason among many others. But if we are not going to be as generous to senior citizens as we are to ourselves today, then we are going to have to, in my view, bring ourselves down. I would rather bring everyone else up, but what is fair for them is fair for us.

I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. I yield back my time and wish to vote now.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The question is on agreeing to amendment No. 957.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.,

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''yea''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 93, nays 3, as follows:

[Rollcall Vote No. 237 Leg.]

YEAS—93

Akaka	Collins	Graham (SC)
Alexander	Conrad	Grassley
Allard	Cornyn	Gregg
Allen	Corzine	Hagel
Baucus	Craig	Harkin
Bayh	Crapo	Hatch
Bennett	Daschle	Hutchison
Biden	Dayton	Inhofe
Bond	DeWine	Inouye
Boxer	Dodd	Jeffords
Brownback	Dole	Johnson
Bunning	Domenici	Kennedy
Burns	Dorgan	Kohl
Byrd	Durbin	Kyl
Cantwell	Edwards	Landrieu
Carper	Ensign	Lautenberg
Chafee	Enzi	Leahy
Chambliss	Feingold	Levin
Clinton	Feinstein	Lincoln
Cochran	Fitzgerald	Lott
Coleman	Frist	Lugar
McCain	Reed	Snowe
McConnell	Reid	Specter
Mikulski	Roberts	Stabenow
Miller	Rockefeller	Stevens
Murkowski	Santorum	Sununu
Murray	Sarbanes	Talent
Nelson (FL)	Schumer	Thomas
Nelson (NE)	Sessions	Voinovich
Nickles	Shelby	Warner
Pryor	Smith	Wyden

NAYS—3

Bingaman	Breaux	Hollings

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The amendment (No. 957) was agreed to.

AMENDMENT NO. 1002

The PRESIDING OFFICER. Under the previous order, there are 2 minutes equally divided prior to the vote on the Lincoln amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Arkansas. The Senator has 1 minute.

Mrs. LINCOLN. Mr. President, I plead with my colleagues to take a very serious look at the amendment before us. I know they are hearing differently from downtown perhaps, but I want them to take a look at a recent CBO study that has indicated to us there is negligible impact in giving parity to the fallback plan.

CBO has given us a recent study that indicates there is negligible impact on the private plans in allowing parity with the fallback plans that may be needed in some of our rural areas to ensure that all of our citizens across this great land get the same benefit in a prescription drug package.

Fifteen of our States have no Medicare+Choice or private plans currently. We know it is going to be difficult. Let's make sure a fallback plan is there for seniors, that the continuity is there for them. All we want to do is make sure they will have the same 2-year contract cycle that the private plans will have.

Again, approximately 80 percent of the people in this country are in fee-for-service plans. Let's make sure those who are in our rural States are going to see the parity in these two plans. Just remember, if the private plans are not there or happen to be there, there will be no fallback plan, so you do not have any problem with that.

I thank the Chair.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. LINCOLN. I encourage my colleagues to vote for this amendment.

The PRESIDING OFFICER. Who yields time?

The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I oppose the amendment. First off, it is bad enough to have one fallback, which I believe will dramatically discourage private plans from participating in a stand-alone drug benefit. To have two is even worse.

The fact is, the Secretary has the authority under this legislation to balance the risk. With a fallback plan,

there is no risk on the private sector. All the risk for a plan is on the public sector. We give the Secretary the ability to dial back the risk to everything but zero, and the fallback plan is zero. We believe giving the Secretary the discretion will at least encourage the private sector to come in, which they will under this bill, and take some risk, which means they will have some incentive to control costs. If they have no risk, they have no incentive and, thereby, the cost of the program goes up.

Having one fallback plan is a very bad idea. Expanding this very bad idea is a worse idea, and I hope we vote against the amendment.

I ask unanimous consent that the remaining two votes in this series be limited to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SANTORUM. Mr. President, I move to table the amendment and ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''no''.

The PRESIDING OFFICER (Mrs. DOLE). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 51, nays 45, as follows:

[Rollcall Vote No. 238 Leg.]

YEAS—51

Alexander	Dole	McCain
Allard	Domenici	McConnell
Allen	Ensign	Murkowski
Baucus	Enzi	Nickles
Bennett	Fitzgerald	Roberts
Bond	Frist	Santorum
Breaux	Graham (SC)	Sessions
Brownback	Grassley	Shelby
Bunning	Gregg	Smith
Burns	Hagel	Snowe
Chambliss	Hatch	Specter
Cochran	Hutchison	Stevens
Coleman	Inhofe	Sununu
Cornyn	Jeffords	Talent
Craig	Kyl	Thomas
Crapo	Lott	Voinovich
DeWine	Lugar	Warner

NAYS—45

Akaka	Clinton	Edwards
Bayh	Collins	Feingold
Biden	Conrad	Feinstein
Bingaman	Corzine	Harkin
Boxer	Daschle	Hollings
Byrd	Dayton	Inouye
Cantwell	Dodd	Johnson
Carper	Dorgan	Kennedy
Chafee	Durbin	Kohl
Landrieu	Miller	Reid
Lautenberg	Murray	Rockefeller
Leahy	Nelson (FL)	Sarbanes
Levin	Nelson (NE)	Schumer
Lincoln	Pryor	Stabenow
Mikulski	Reed	Wyden

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The motion was agreed to.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 982

The PRESIDING OFFICER. Under the previous order, there are now 2 minutes for debate prior to a vote in relation to the Lautenberg amendment, No. 982.

Who yields time?

The Senator from New Jersey.

Mr. LAUTENBERG. Madam President, my amendment is very simple. It says, if you are going to give, then don't take it away. If you are going to give a prescription drug benefit, then, by golly, start it in a timely manner, and start it, let's say, by July of 2004 instead of 2006.

What kind of a benefit is this when 5.5 million of our present living seniors, I am sorry to say, will not be here at that time, 30 months hence. In 11 months, President Lyndon Johnson initiated the idea of Medicare and had it passed and in place—11 months. Why in the world is it going to take 30 months?

I do not believe we ought to be looking at these discount cards, which are available generally in the community today, as the stopover until 30 months have gone by. It is an outrage that this date is chosen, I think not because they want to delay the benefit for seniors but, rather, because it coincides with an election. I do not think we ought to stand for it.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Iowa.

Mr. GRASSLEY. Madam President, I sympathize with those who feel a need to get this program going sooner than we have it in this legislation. But the fact is, CMS has told us it is physically impossible to get this benefit up and running in the year 2004. Now, knowing that, we have provided a prescription drug discount card, starting on January 1, 2004, in order to get immediate relief from the high cost of prescriptions for our seniors.

The amendment would spend close to $24 billion in fiscal year 2004—the amendment that is before us—and that is money that is not in the budget. We deal with the needs of our seniors in a fair way with this bill, the discount card, and the $600 help for them for each of the next 2 years. So I urge my colleagues to take all this into consideration and oppose the amendment.

Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to amendment No. 982.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Kansas (Mr. BROWNBACK) and the Senator from Colorado (Mr. CAMPBELL) are necessarily absent.

I further announce that if present and voting the Senator from Kansas (Mr. BROWNBACK) would vote ''no''.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 54, as follows:

[Rollcall Vote No. 239 Leg.]

YEAS—41

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Pryor
Byrd	Harkin	Reed
Cantwell	Hollings	Reid
Carper	Inouye	Rockefeller
Clinton	Johnson	Sarbanes
Conrad	Kennedy	Schumer
Corzine	Kohl	Stabenow
Daschle	Lautenberg	Talent
Dayton	Leahy	Wyden
Dodd	Levin	

NAYS—54

Alexander	Dole	McCain
Allard	Domenici	McConnell
Allen	Ensign	Miller
Baucus	Enzi	Murkowski
Bennett	Fitzgerald	Nelson (NE)
Bond	Frist	Nickles
Breaux	Graham (SC)	Roberts
Bunning	Grassley	Santorum
Burns	Gregg	Sessions
Chafee	Hagel	Shelby
Chambliss	Hatch	Smith
Cochran	Hutchison	Snowe
Coleman	Inhofe	Specter
Collins	Jeffords	Stevens
Cornyn	Kyl	Sununu
Craig	Landrieu	Thomas
Crapo	Lott	Voinovich
DeWine	Lugar	Warner

NOT VOTING—5

Brownback	Graham (FL)	Lieberman
Campbell	Kerry	

The amendment (No. 982) was rejected.

Mr. GRASSLEY. Madam President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. Madam President, the two leaders have met and talked to the managers. We will have, in approximately 30 minutes, two votes. Senator DODD has agreed to take 20 minutes on his two amendments. He can divide it however he deems appropriate. Following that, the Senate will still be in

session. People will offer amendments, if they desire, but it is contemplated these two votes will be the last votes of the evening.

The PRESIDING OFFICER. The Senator from Connecticut is recognized.

Mr. DODD. Madam President, I ask unanimous consent that the pending amendment be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 998

Mr. DODD. Madam President, I call up amendment No. 998.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Connecticut [Mr. DODD] proposes an amendment numbered 998.

Mr. DODD. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To modify the amount of the direct subsidy to be provided to qualified retiree prescription drug plans)

On page 129, strike lines 3 through 20, and insert the following:

''(2) AMOUNT OF PAYMENT.—The amount of the payment under paragraph (1) shall be an amount equal to the monthly national average premium for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

Mr. DODD. Madam President, this first amendment is intended to address one of the major problems with this bill, and that is the impact the legislation could have on Medicare beneficiaries who are currently receiving prescription drug coverage under the employer-sponsored retiree benefit plans.

I will quickly point out to my colleagues who may be saying we voted on this with the Rockefeller amendment that this is very different. The Rockefeller amendment was designed to provide encouragement to employers to supplement the existing prescription drug benefit. This amendment is designed to provide that encouragement only to employers who would be picking up the total cost of the prescription drug benefit, not just acting as a supplement. So it is very different. It is not the wraparound. This is an optional choice by the retiree or the employer. If they are the primary provider of the drug benefit, they would be covered by this amendment.

For employers intending to act as a supplement to the coverage, we decided that today; unfortunately, it was voted down. With that in mind, clearly in this bill most of us believe what we ought to be trying to do is support, not supplant, the valuable efforts of employers already providing prescription coverage to retirees.

As presently written, I am concerned the bill would lead many retiree benefit plans to scale back or drop entirely the prescription drug coverage they presently provide. However, this amendment would provide an increased subsidy to employers, because we want to encourage them to provide this benefit to retirees. It seems to me it is in our interest to encourage them to stay involved. They would get a subsidy, as long as they continue to offer prescription drug coverage to retirees only as the primary provider, not as a supplement—not as a wrap around the new Medicare benefit.

The scope of this problem is not small at all. In fact, I was surprised to learn how many seniors would be impacted by the unintended change to retiree benefit coverage. About one-third of all Medicare beneficiaries receive prescription drug coverage through an employer-sponsored health care plan. That is by far the largest source of prescription drug coverage for seniors.

These plans have played a very critical role in providing security to seniors, while Congress has been unable over the last number of years to pass a prescription drug benefit plan under Medicare. Retiree benefit plans should continue, in my view, to play that role even after a drug benefit plan is enacted. In many cases, the drug coverage provided by retiree benefit plans is significantly more generous than the plan we are debating here.

Furthermore, many seniors have become familiar and comfortable with the coverage offered by their former employers.

Understandably, they do not want to give it up for a plan about which they are confused and uncertain or may not be as beneficial to them.

We should be doing, in my view, everything in our power to provide these seniors with a choice, with the option of staying with their employer-sponsored plan. Thus, this amendment.

Unfortunately, the option may not be available for many seniors. That is why I put up this chart. I wish to focus the attention of those who may be following this debate to the left side of this chart. The right side I will talk about briefly, but the most significant numbers are on the left side of the chart. I will get to them in a minute.

While the numbers vary slightly, depending upon which study one consults, they come to the same conclusions, roughly the same numbers, and they are very disheartening. Between 1993 and 2001, the percentage of large employers, those who employ more than 500 people, offering coverage to Medicare-eligible retirees dropped from 40 to 23 percent, almost in half over 7 or 8 years. In the last 2 years, 13 percent of all employers offering future retiree coverage have elected not to do so. Those retaining coverage are experiencing annual cost increases on the order of 14 percent. It has been tremendously expensive. As a result, they are substantially raising the cost-sharing burdens for individuals enrolled in these plans.

The chart on the left-hand side illustrates the crisis that employer-sponsored plans are facing today and are going to continue to face in the future. The numbers are based on a survey conducted by the Kaiser Family Foundation and Hewitt Associates in December of 2002.

The graph shows that the actions large employers have taken over the last 2 years to deal with the rapidly increasing retiree health care cost—these numbers may not be clear to everyone, so I will recite them—a large number of employers have increased individual costs in some way. Forty-four percent have increased retiree contributions to premiums, while 36 percent increased cost sharing. In addition, 14 percent have shifted all costs to the individual retiree, and 13 percent have eliminated the plans altogether. Finally, nearly half of employers surveyed increased cost sharing for prescription drugs, as shown by the bar depicting 49 percent.

The numbers on this chart do not bode well, is the point I am trying to make, for those seniors who currently receive health care benefits from their former employers. Given the enormous financial pressures being felt by employers and the encouragement this bill already provides—in the form of a 64 percent subsidy—to keep employers from dropping coverage, it seems to me that if the employees decide to stay with their existing coverage, we believe that subsidy ought to go from 64 percent to 100 percent of the national average premium. That is what we are trying to do with this amendment.

The Congressional Budget Office has estimated that almost 40 percent of seniors who currently have their prescription drug medicines covered by retiree benefit plans would lose their coverage under the plan before us. So even with the 64 percent subsidy, 37 percent of retirees would be dropped from these plans. We are raising through this amendment that subsidy to 100 percent which we think will do a lot to keep these employer-based plans in place so that retirees would have that option of sticking with those retiree plans.

I supported the Rockefeller amendment. I mentioned that earlier. This is different. This is very different. If you are just supplementing the benefit plan, then you would not be covered by the Dodd amendment. That was the Rockefeller amendment, and the Senate voted it down. My amendment says only if you are the primary provider of the prescription drug benefit would you get the kind of subsidy we are talking about, from 64 to 100 percent. That would mean approximately an additional $400 a year per retiree paid to the employer. This would encourage employers to retain the full prescription drug coverage they presently provide rather than cutting back coverage and simply supplementing a new Medicare benefit.

The underlying bill has a provision that would provide a subsidy to employers for every Medicare-eligible retiree who elects to remain in an employer-sponsored plan as an alternative

to the Medicare prescription drug plan. That subsidy would be approximately, as I mentioned, 64 percent of the national average premium for prescription drug coverage.

This amendment would very simply increase that subsidy to the full national average premium. This would mean an additional $35 a month per beneficiary or roughly $400 a year paid directly to employer-sponsored plans as long as they continue to offer an alternative to Medicare prescription drug coverage, bringing the total subsidies to almost $100 per month when we combine the 64 percent that is in the bill and what we are adding with this amendment.

To receive this subsidy, employers would have to offer a prescription drug plan that is competitive with the Medicare benefit because the subsidy would only be paid for beneficiaries who remain in the employer-sponsored plan and do not enroll in Medicare Part C or D.

We simply cannot allow retiree benefit plans to disappear. That would be a great mistake, in my view. This amendment is designed to keep them if we can. It is a modest amendment considering the benefits that could accrue to the retirees, giving them the option of sticking with an employer-based plan.

If CBO is right, under the plan before us, almost 40 percent of these retirees will lose that prescription drug coverage under their employer-based plans. I do not think we want to have that happen. I urge the adoption of this amendment, and I hope my colleagues will be supportive of it.

I see the chairman of the committee who I know wants to respond to my amendment.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I wish to propound a unanimous consent request.

I ask unanimous consent that Senator DODD have up to 20 minutes and Senator GRASSLEY up to 10 minutes for debate on amendment Nos. 970 and 998 concurrently. I further ask unanimous consent that following that debate, the Senate proceed to a vote in relation to the amendment No. 970, to be followed by a vote in relation to amendment No. 998, with no second-degree amendments in order to the amendments prior to the vote. Finally, I ask unanimous consent that at 10 a.m. tomorrow the Senate proceed to a vote in relation to the Grassley, or his designee, amendment, regarding the benchmark, with no amendments in order to the amendment prior to the vote; provided further, that this vote be subject to the approval of both leaders.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Reserving the right to object.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, it is my understanding the Senator from Connecticut has graciously indicated the time he has used would be counted toward this time.

Mr. DODD. That is correct.

Mr. REID. That being the case, the vote will occur around 6:15 p.m., for the information of Members.

The PRESIDING OFFICER. Approximately 6:20 p.m. Is there objection? Without objection, it is so ordered.

Mr. DODD. Mr. President, if I can finish, I can give the chairman a chance to respond.

I ask unanimous consent that a letter signed by 33 of the labor unions in this country in support of my amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JUNE 23, 2003.

DEAR SENATOR: If the Medicare drug bill before the Senate, S. 1, becomes law, 37 percent of retirees who now have employer-sponsored health benefits will lose that coverage. That's 4.4 million retirees that will be made worse off if S. 1, as drafted, is enacted into law. Such an act will represent an enormous and irreversible blow to the employer-based system that is the backbone of our nation's health care system.

As you know, retiree health coverage is already in crisis. Drug costs constitute 40 to 60 percent of employers' retiree health care costs, and steep price increases are prompting employers to eliminate drug benefits, cap their contributions or drop retiree coverage altogether. In fact, just 34 percent of all large firms (200 or more employees) offered retiree benefits in 2002, down from 68 percent of all large firms in 1988.

Both public and private employers need immediate relief for their retiree prescription drug costs, but S. 1, as now drafted, will exacerbate an already dire situation for retiree coverage by discriminating against retirees with employer-sponsored coverage.

By using a trick definition of out of pocket costs—''true out of pocket''—S. 1 will effectively deny retirees catastrophic coverage by not counting any drug costs covered through an employer plan. This ensures seniors with retiree benefits will get less Medicare coverage than any other beneficiary. As a result, employers that choose to ''wrap around'' the Medicare benefit and provide assistance for costs not covered by Medicare will find the gap in coverage does not end for these retirees.

Two amendments will be offered to address this critical flaw. The first, offered by Senator Rockefeller, would eliminate the ''true out of pocket'' definition so that retirees receive the same benefit as all other beneficiaries. The second amendment, to be offered by Senator Dodd, would increase the subsidy to employers that retain retiree benefits.

Although some may claim that the ''true out of pocket'' trick will save money for Medicare, any provision that encourages employers to drop their retiree benefits will only end up costing the federal government more—and hurt millions of seniors in the process. Seniors who have retiree benefits have worked a lifetime and made wage concessions over the years with the expectation that they would have retiree benefits. To change the rules of the game at this point and give them less than other Medicare beneficiaries is patently unfair.

We urge you to support the amendments aimed at encouraging both public and private employers to continue providing retiree health benefits. Congress must enact a drug benefit that supports, not threatens our fragile employer-based system of health coverage.

We have many other concerns with the Senate bill, including the enormous gap in coverage and the reliance on uncertain and historically unstable private insurance plans. And we have very grave concerns that the conference report you will be asked to consider will incorporate elements of the House bill that are entirely unacceptable to the millions of American we represent. In particular, the House bill would introduce full competition into Medicare beginning in 2010—a blatant attempt to undermine the traditional Medicare program and start it on a ''death spiral'' of caring for the sickest beneficiaries and unsustainable costs.

We strongly believe that adding a prescription drug benefit to Medicare is the most urgently needed reform and one that has been promised to our nation's elderly and disabled. However, we cannot accept legislation that does so at the expense of retirees who now have employer-sponsored coverage and the very future of Medicare.

Thank you for your consideration.

Sincerely,

John J. Sweeney, President, AFL–CIO; Ron Gettelfinger, President, United Auto Workers; John J. Flynn, President, International Union of Bricklayers and Allied Craftworkers; Morton Bahr, President, Communications Workers of America; Harold A Schaitberger, President, International Association of Fire Fighters; Douglas H. Dority, International President, United Food and Commercial Workers.

James A. Grogan, Jr., President, Asbestos Workers, International Association of Heart and Frost Insulators; Frank Hurt, President, Bakery, Confectionary, Tobacco Workers and Grain Millers International Union; Edward C. Sullivan, President, Building and Construction Trades; Edwin D. Hill, President, International Brotherhood of Electrical Workers; Patricia Friend, International President, Association of Flight Attendants; Bobby L. Harnage Sr., President, American Federation of Government Employees.

David Holway, President, National Association of Government Union Employees/International Brotherhood of Police Officers; S. Richard Elliott, President, International Union of Journeymen, Horseshoers, United Services and Allied Trades; Terence M. O'Sullivan, President, Laborers' International Union; R. Thomas Buffenbarger, President, International Association of Machinists and Aerospace Workers; Thomas F. Lee, President, American Federation of Musicians of the United States and Canada.

Gregory Junemann, President, International Federation of Professional and Technical Engineers; Andrew L. Stern, President, Service Employees International Union; Gerald W. McEntee, President, American Federation of State, County and Municipal Employees; Sandra Feldman, President, American Federation of Teachers; Sonny Hall, President, Transport Workers Union of America; Donald Wightman, President, Utility Workers Union of America; George Tedeschi, President, Graphic Communications International Union; Joseph J. Hunt, General President, Iron Workers, International Association of Bridge, Structural, Ornamental and Reinforcing.

John M. Bowers, President, International Longshoremen's Association; Cecil E.

Roberts, President, United Mine Workers of America; Boyd D. Young, President, PACE International Union; Joe L. Greene, President, American Federation of School Administrators; Michael J. Sullivan, General President, Sheet Metal Workers International Union; Leo W. Gerard, President, United Steelworkers of America; James P. Hoffa, General President, International Brotherhood of Teamsters; Robert A. Scardelletti, President, Transportation Communications International Union.

Mr. DODD. Mr. President, I will read a pertinent passage because this is really the heart of this issue. I mentioned earlier, one-third of all retirees get coverage under the private employer-based plans. If CBO is right, almost 40 percent of retirees will lose their coverage under this bill, and employers would start dropping them because they do not get the subsidies, then I think we have to understand what the implications mean for a lot of people. I do not believe my colleagues intend this to be the case, but this is what is going to happen if we are not careful.

The letter reads in part:

If the Medicare drug bill before the Senate, S. 1, becomes law, 37 percent of retirees who now have employer-sponsored health benefits will lose that coverage.

That is according to CBO.

That's 4.4 million retirees that will be made worse off if S. 1, as drafted, is enacted into law. Such an act will represent an enormous and irreversible blow to the employer-based system that is the backbone of our nation's health care system.

The letter goes on:

. . . any provision that encourages employers to drop their retiree benefits will only end up costing the federal government more—and hurt millions of seniors in the process. . . .

We urge you to support the [Dodd] amendment aimed at encouraging both public and private employers to continue providing retiree health benefits. Congress must enact a drug benefit that supports, not threatens, our fragile employer-based system of health coverage.

That is what my amendment is designed to do: to provide that subsidy if the retiree takes the option of continuing in the employer-based plan as the primary provider for health care coverage. If that is the case, then I think we ought to provide that encouragement and inducement. They make a huge difference in people's lives. If CBO is right and we do not adopt this amendment, and 4.5 million people have a worse plan as a result of our action, we have taken a step back rather than a step forward for that many seniors in our country. I don't know of anyone in this Chamber who would like to be a party to that.

For those reasons, I hope my colleagues could support the man from Connecticut on his amendment.

Mr. GRASSLEY. I am glad to speak about the man from Connecticut and his amendment but not to support it.

First of all, we need to remember, with or without this subject before the Senate, these plans could be dropped without any hesitation. We can have the prescription drug plan before the Senate, and there could be some reason some companies would drop that. But right now, remember, our passage of this legislation is very much to fill a gap. We are worried about people who do not have any coverage whatever.

As I have said before, we are all very concerned about the future of retirees' benefits and making sure retirees are treated fairly. Under the beneficial before the Senate, retirees get the same protection from high prescription drugs and the costs as any other beneficiary. That is a generous subsidy, far greater than they currently get, which would be zero.

The fact is, typical retiree plans provide much more generous coverage, and the beneficiaries spend much less out of pocket for their prescriptions.

There has been a great deal of interest in the assumption by the Congressional Budget Office that corporations are going to drop their coverage of prescription drugs for about 37 percent of the retirees in retiree health plans over the next 10 years. What we cannot forget is employers, as I indicated, are already dropping or, maybe more, scaling back retiree health benefits not because of our legislation but because retiree health benefits are rising because of very high health care costs. They have already been dropping plans or cutting them back for at least a decade, a point made by my colleague, Senator DODD.

We have worked hard to address this problem in the underlying legislation. One of the most significant future liabilities faced by retiree plans is the cost of prescription drugs. We have given employers serious and generous subsidies. The Dodd amendment proposes to boost subsidies for employers beyond the 64 percent we have given them already. This change would send millions more in taxpayers dollars to these corporations during the next decade. We had to put priorities first.

We have $400 billion. We have looked at States and the problems of dual eligibles. We looked at corporate retiree plans and what might happen and what can we do to keep those that are going out of business or dumping theirs on a government plan. We have worked with a lot of different problems. We have had to do the best we can to squeeze within that $400 billion. We have tried to help the States to some extent on dual eligibles. We are trying to help corporations with incentives not to dump their retirees on this plan. I can go down a long list we have tried to squeeze in and prioritize.

The overriding goal was to help those who had no drug plans whatever. That was very much a high priority. We have maybe 30 percent or a little more on private plans. We have people on Medicare with Medigap policies. We have people who are duly eligible subject to Medicaid. But we have 30 percent or more with zilch. We go beyond just helping those who do not have any plan. But that has been our priority. We tried to do it in a way that people who have better—and maybe most corporate retiree plans do have better incentives than what we can provide—and they can continue to have better. But we cannot control entirely what corporations are going to do. Particularly, you cannot do that on the amount of money we have here.

As I indicated, this is a very expensive amendment that we cannot squeeze into the $400 billion.

I urge my colleagues to defeat the amendment. I yield the floor.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. I will take 1 minute on this amendment and move to my second amendment.

This is an optional choice. We are not requiring employers to retain an employer-based plan. We are saying we know already, based on CBO's analysis, that close to 40 percent of people under the employer-based plans will be dropped. We know that.

Our primary responsibility in this bill is to provide a good prescription drug benefit for people. We do not want to be in a situation of actually causing people to have a worse plan than they have.

My point is not to increase spending but to say, if you are going to provide prescription drug coverage as an employer—and I want you to continue doing this; and we are being told 37 percent of the people will be dropped—we will increase the subsidy. To encourage employers to continue doing it seems to me to be in our interest. That is why I offer this amendment and why it is so strongly supported by labor unions who believe this will be a major blow to almost 4.5 million retirees in the country. I urge adoption of this amendment.

AMENDMENT NO. 970

The second amendment I call up is amendment No. 970, and I ask for its immediate consideration.

The PRESIDING OFFICER. That amendment is pending.

Mr. DODD. Let me briefly explain this amendment. I commend the committee.

This bill does an awful lot for people who are really hurting. I want the chairman to know I strongly support his efforts. Those who are really hurting get real help with this bill. I commend the committee for focusing on that. I commend him for it.

What this amendment does is a little different. We have all been talking about donut holes. People watching this debate may wonder what we are talking about, but the donut hole is in the plan when you reach a certain level of your costs of prescription drugs. Even though you keep paying the premiums of $35 a month, if your costs run somewhere around $4,500 to $5,800, during that period you are in the eye of the hurricane, and you do not get any help during that period.

That is not true if you are below 160 percent of poverty. If you are below 160 percent of poverty, we will provide help to you even while you are in the donut hole.

My amendment effects those in the donut hole who are between 160 and 250 percent of poverty. That is an individual who makes $22,000 a year or a couple earning $30,000 a year. These are people who are really hurting out there as well. They are not as desperately poor as those at 160 percent of poverty, but they are not much better off. But just in the donut hole, could we say that those people might get a 50/50 deal in the donut hole, between 160 and 250 percent of poverty? In that one set of circumstances where the costs are running from $4,500 to $5,800, you get a 50/50 deal if you are making $22,500, or a couple, $30,000, that is what the amendment does.

I know the chairman is going to say these are great ideas and there is a cost associated, and there is. But we ought to provide some help to people in those earnings groups—$22,000 if you are single or $30,000 as a couple. These are probably cancer patients or patients with serious medical costs. If you are paying somewhere around $4,500 a year, up to $5,800 a year, you have a serious health care problem. If you are making $22,000 or $30,000, as an individual or a married couple, then to provide 50 percent of the cost of those prescription drugs while you are in that donut hole I do not think is asking too much of us.

We should add just a little bit to accommodate these not even middle-income people. It would be an unfair description to say these are middle-income people. There is nothing magic about 250 percent. I just tried to reach out a bit to that constituency here that will continue paying the $35 a month. They have to do that. They do not get anything. If we could just reach a little further to that constituency, beyond the 160 percent, between $4,500 and $5,800 in total spending. We try to provide an additional bit of help for you, 50 percent of that cost. We can't pick up all of it, that would probably be too expensive. I don't know what the CBO numbers would be, but we will put you in the 50/50 bracket up to 250 percent of poverty just while you are in that situation. That is what the amendment does. It is no more complicated than that.

Again, I compliment the chairman. They have done a very good job taking care of the very desperately poor in the country. But for people who are not quite desperately poor—although I suggest some may tell you that living on $22,000 a year as a single person or a couple over the age of 65 with $30,000 worth of income, they are not out partying. These people probably make choices between food and rent and medicines, particularly if you are paying $4,500 a year or up to $5,800 a year for prescription drugs. That comes off the $22,000 or your $30,000. You do not have to do the math to know where you are living, what circumstances you are under.

So this is designed to provide some additional relief for people in that category, moving it up just a little bit, up to that 250 percent from 160 percent while you are in the donut hole, only there, to get a 50/50 break. You still pay 50 percent of the cost. You don't get 100 percent relief, but 50 percent of the cost, and that is what the second amendment is designed to do.

I apologize for racing, but I am trying to get this in in the 5 minutes. This is obviously complicated stuff. I am trying to accommodate my colleagues who I know have other engagements this evening to explain what the amendments do. The time does not justify the context, as to how important this would be to a lot of people in this country. I don't know the numbers of the people in this income category, but I have to believe before we get done with this, to provide some additional help for people in that category ought not to be too much of a stretch when you consider that $22,450 for an individual and $30,000 for a couple is going to put a lot of burden, a lot of pressure on you if you are already paying somewhere between $4,500 and $5,800 in prescription drug costs. This amendment would help those people.

I hope the man from Connecticut might impress the chairman on this one with his support. Hope springs eternal. I keep knocking on the door, seeing if I can't get some help.

Mr. KENNEDY. I commend Senator DODD for offering this important amendment today. This amendment will address one of the gaping holes in this plan—its failure to treat retirees and retiree health plans fairly. Today, we have the opportunity—and the obligation—to correct that unfairness.

Ten million senior citizens depend on retiree health plans to fill the gaps in Medicare. Especially given the limitations of the drug benefit we are debating, supplemental coverage from retiree health plans is crucial. But retiree health plans are being abandoned or cut back all over the country—and prescription drug costs are a key part of the problem. For retirees who are over 65, prescription drugs make up about half of all plan costs—and as much as 80 percent of recent cost increases.

But the prescription drug plan before us treats those plans unfairly, by taking the unprecedented step of making senior citizens with retiree health plans second class citizens under Medicare. The Congressional Budget Office has concluded that even with the new assistance provided under this plan, one-third of all retirees—4 million senior citizens—could lose their supplemental drug coverage. That should be unacceptable to every Senator.

The issue is not one of providing a bail-out or a windfall to retiree health plans. It is one of simple fairness. Currently, whenever Medicare covers a benefit or service, Medicare is the primary payer for that service. If a retiree health plan covers the service, it pays only for what Medicare does not cover.

The reason for that is straightforward. Employers pay taxes to support the Medicare Program. So do retirees. So do active workers who accept lower wages during their working years in order to have supplemental retirement health care in their retirement years.

But under this legislation, these workers and these employers do not get the full benefit of their contribution to the drug benefit. Because of the ''true out-of-pocket'' concept included in the bill, Medicare does not pay for catastrophic expenses of these workers, even though the cost of covering these expenses accounts for more than one-third the cost of the current bill.

And the higher the costs the retiree faces, the more the discrepancy between what Medicare pays for the retiree with employer-sponsored insurance and what Medicare pays for all other senior citizens grows. If the individual's drug costs are $6,000, Medicare pays $2,113 for the retiree with insurance but $2,281 for all other senior citizens. If the individual's drug costs are $8,000, Medicare still pays $2,113 for the retiree with employer-sponsored insurance, but $4,081 for all other senior citizens. And if the individual's drug costs are $10,000, Medicare still pays just $2,113 for the retiree, but pays $5,881 for all other senior citizens.

This is double taxation at its worst. These retired workers and companies are taxed twice. They pay once to support the Mecicare program. Then they are forced to pay again by being denied the Medicare benefits their contributions have earned. During the debate on the tax bill we heard a lot about the injustice of double taxation of dividends from the other side of the aisle. Apparently, for them, double taxation of the unearned income of millionaires and billionaires is wrong, but double taxation of moderate income retired senior citizens is just fine.

The fact is that it is not fine. The American people understand that it is wrong. American companies struggling to provide for their retired workers in this sour economy understand that is wrong. The Senate should understand that it is wrong, too, and right this injustice.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, how much time do I have?

The PRESIDING OFFICER. The Senator has 4 minutes.

Mr. DODD. I had 5.

Mr. GRASSLEY. First, let me explain to the distinguished Presiding Officer why we refer to ''the man from Connecticut.'' When I was going to yield him some time, I didn't think of the word ''Senator.'' I said I will give 1 minute to the man from Connecticut, and I apologize.

First of all, I wish I had an exact number for this amendment. It has

some costs, but I do not have an official score from the Congressional Budget Office so I cannot say that this costs X number of billions of dollars at this point. But it does have some cost.

I am going to try to convince the Senator from Connecticut that we have done a lot in this legislation for people who are low income. Maybe it doesn't go as high up the economic ladder as he would like to have us go. But my point is we have done an awful lot.

We worked very hard to minimize the gap in coverage with resources provided in the budget resolution which would be roughly $400 billion. The bill also provides generous coverage to lower income beneficiaries, those who have income below about $15,000, and couples with incomes below about $20,000. They, in fact, have no gap in coverage. That is 44 percent of Medicare beneficiaries who are completely unaffected by the benefit limit.

In the writing of this bill, a conscious decision was made to devote excess dollars to filling in the gap in coverage for all seniors. Under the underlying bill, the average senior at this income level will still save more than $1,600 annually off the drug spending after paying an affordable monthly premium of $35 per month. This is a savings of about 53 percent off annual drug costs for the average senior who would enroll in the drug benefit.

Let me remind everybody, this drug benefit is optional. People do not have to join it. If anybody is saying I don't want to pay $35 per month to get this sort of coverage, then that person does not have to pay $35 per month for coverage because this is a voluntary program. So the people who enroll in this program would save that $1,600, even beyond the $35-per-month premium.

While I appreciate what the Senator from Connecticut is trying to do, it cannot possibly fit within the $400 billion that we have. We had to draw a limit someplace. We drew the limit at 160 percent of poverty. So I cannot support his amendment. I am sorry to say that to the Senator from Connecticut.

The PRESIDING OFFICER. The Senator from Connecticut.

Mr. DODD. I thank the chairman. He has been very gracious. This is my last amendment. I have tried vainly over here in the last couple of days with some amendments—I don't know what the implications are; I appreciate his candor, in terms of not knowing the cost of this amendment—that would fill in the hole, to go from 160 to 250, for people in that category. The reason I offered it is it occurred to me if you are paying that much in prescription drugs, somewhere around $5,000 a year for prescription drugs, and you are making $30,000 as a couple or $22,000 as an individual, you probably have a pretty serious illness if you are paying about $5,000 in prescription drug costs.

It occurs to me that during that hole, we might try to do a little more. We have done that, as the chairman says, very graciously for the desperately poor in this country.

For those reasons, I urge the adoption of the amendment. I will let the chairman proceed. The first amendment, I guess, we will do in that order.

Mr. GRASSLEY. I yield any time I have and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to amendment No. 970.

Mr. DODD. There are two amendments. Amendment No. 998?

The PRESIDING OFFICER. We will vote on one at a time. Amendment No. 970 is first.

Mr. GRASSLEY. Mr. President, while I am at it, I would like to ask for the yeas and nays on both the Dodd amendments.

The PRESIDING OFFICER. Is there objection to that request?

Without objection, it is so ordered. The yeas and nays are in order.

Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The question is on agreeing to the amendment. The yeas and nays have been ordered.

The clerk will call the roll on amendment No. 970.

The assistant legislative clerk called the roll.

Mr. MCCONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) and the Senator from South Carolina (Mr. GRAHAM) are necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Florida (Mr. GRAHAM) and the Senator from Massachusetts (Mr. KERRY) would each vote ''yea.''

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 54, as follows:

[Rollcall Vote No. 240 Leg.]

YEAS—41

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Nelson (NE)
Byrd	Harkin	Pryor
Cantwell	Hollings	Reed
Carper	Inouye	Reid
Clinton	Johnson	Rockefeller
Conrad	Kennedy	Sarbanes
Corzine	Kohl	Schumer
Daschle	Lautenberg	Stabenow
Dayton	Leahy	Wyden
Dodd	Levin	

NAYS—54

Alexander	DeWine	McCain
Allard	Dole	McConnell
Allen	Domenici	Miller
Baucus	Ensign	Murkowski
Bennett	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Santorum
Brownback	Grassley	Sessions
Bunning	Gregg	Shelby
Burns	Hagel	Smith
Chafee	Hatch	Snowe
Chambliss	Hutchison	Specter
Cochran	Inhofe	Stevens
Coleman	Jeffords	Sununu
Collins	Kyl	Talent
Cornyn	Landrieu	Thomas
Craig	Lott	Voinovich
Crapo	Lugar	Warner

NOT VOTING—5

Campbell	Graham (SC)	Lieberman
Graham (FL)	Kerry	

The amendment (No. 970) was rejected.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. NICKLES. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

VOTE ON AMENDMENT NO. 998

The PRESIDING OFFICER. The question is on agreeing to amendment No. 998. The yeas and nays have been ordered. The clerk will call the roll.

The legislative clerk called the roll.

Mr. MCDONNELL. I announce that the Senator from Colorado (Mr. CAMPBELL) is necessarily absent.

Mr. REID. I announce that the Senator from Florida (Mr. GRAHAM), the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote ''yea''.

The PRESIDING OFFICER (Mr. TALENT). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 41, nays 55, as follows:

[Rollcall Vote No. 241 Leg.]

YEAS—41

Akaka	Dorgan	Lincoln
Bayh	Durbin	Mikulski
Biden	Edwards	Murray
Bingaman	Feingold	Nelson (FL)
Boxer	Feinstein	Nelson (NE)
Byrd	Harkin	Pryor
Cantwell	Hollings	Reed
Carper	Inouye	Reid
Clinton	Johnson	Rockefeller
Conrad	Kennedy	Sarbanes
Corzine	Kohl	Schumer
Daschle	Lautenberg	Stabenow
Dayton	Leahy	Wyden
Dodd	Levin	

NAYS—55

Alexander	Burns	DeWine
Allard	Chafee	Dole
Allen	Chambliss	Domenici
Baucus	Cochran	Ensign
Bennett	Coleman	Enzi
Bond	Collins	Fitzgerald
Breaux	Cornyn	Frist
Brownback	Craig	Graham (SC)
Bunning	Crapo	Grassley

Gregg	McCain	Snowe
Hagel	McConnell	Specter
Hatch	Miller	Stevens
Hutchison	Murkowski	Sununu
Inhofe	Nickles	Talent
Jeffords	Roberts	Thomas
Kyl	Santorum	Voinovich
Landrieu	Sessions	Warner
Lott	Shelby	
Lugar	Smith	

NOT VOTING—4

Campbell	Kerry
Graham (FL)	Lieberman

The amendment (No. 998) was rejected.

Mr. REID. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. I ask unanimous consent that the Democratic leader be recognized to speak next, and following his statement the Senator from Georgia be recognized to speak, both as if in morning business. The Senator from Georgia will speak for up to 7½ minutes; I don't know how long Senator DASCHLE is going to speak, but I don't think it will be long.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. While we are waiting for Senator DASCHLE, if we could reverse the order and have the Senator from Georgia proceed.

The PRESIDING OFFICER. The Senator from Georgia.

(The remarks of Mr. MILLER are printed in Today's RECORD under ''Morning Business.'')

(The remarks of Mr. DASCHLE are printed in Today's RECORD under ''Morning Business.'')

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I ask unanimous consent the pending amendment be set aside and Senator CONRAD be recognized to offer a series of amendments, and following his offering amendments the Senator from New York, Senator CLINTON, be recognized to offer her amendments.

I state for the information of Senators, the manager or I will also have some other amendments to offer on behalf of other Senators. Following that, there should be no more business of the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota.

AMENDMENTS NOS. 1019, 1020, 1021

Mr. CONRAD. Mr. President, I say to my colleague who is seeking to also introduce amendments, I will be very brief.

I rise to offer three amendments to the Prescription Drug and Medicare Improvement Act. I send the three to the desk.

The PRESIDING OFFICER. The clerk will report the amendments by number.

The legislative clerk read as follows:

The Senator from North Dakota [Mr. CONRAD], for himself, Mrs. MURRAY, Mr. SMITH, Mrs. LINCOLN, and Mr. JEFFORDS, proposes an amendment numbered 1019.

The Senator from North Dakota [Mr. CONRAD] proposes an amendment numbered 1020.

The Senator from North Dakota [Mr. CONRAD] proposes an amendment numbered 1021.

Mr. CONRAD. I ask unanimous consent the reading of the amendments be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT NO. 1019

(Purpose: To provide for coverage of self-injected biologicals under part B of the medicare program until Medicare Prescription Drug plans are available)

At the end of subtitle B of title IV, insert the following:

SEC. ___. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(W)(i) a self-injected biological (which is approved by the Food and Drug Administration) that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished incident to a physicians' service) that would otherwise be described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

''(ii) a self-injected drug that is used to treat multiple sclerosis;''.

(2) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) are each amended by inserting '', except for any drug or biological described in subparagraph (W),'' after ''which''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)''; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

AMENDMENT NO. 1020

(Purpose: To permanently and fully equalize the standardized payment rate beginning in fiscal year 2004)

Strike section 401 and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(iv)(42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to subclause (II), for discharges''; and

(2) by adding at the end the following new subclause:

''(II) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

(E) by adding at the end the following new clause:

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

At the end of title VI, add the following:

SEC. ___. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)''; and

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98–369).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: ''An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.'';

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

(B) in the final sentence, by striking ''on the date such notice or other information is received'' and inserting ''on the date notice of, or information related to, a primary plan's responsibility for such payment or other information is received''; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: ''In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.''.

(c) CLERICAL AMENDMENTS.—Section 1862(b)(42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

AMENDMENT NO. 1021

(Purpose: To address medicare payment inequities)

At the end of subtitle A of title IV, add the following:

SEC. ___. GEOGRAPHIC RECLASSIFICATION OF CERTAIN HOSPITALS FOR PURPOSES OF REIMBURSEMENT UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring during fiscal year 2004 and each subsequent fiscal year, for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospitals located in the Bismarck, North Dakota Metropolitan Statistical Area are deemed to be located in the Fargo-Moorhead North Dakota-Minnesota Metropolitan Statistical Area.

(b) TREATMENT AS DECISION OF MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD.—

(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of section 1886(d) of the Social Security Act (42 U.S.C 1395ww(d)), any reclassification under subsection (a) shall be treated as a decision of the Medicare Geographic Classification Review Board under paragraph (10) of that section.

(2) NONAPPLICATION OF 3-YEAR APPLICATION PROVISION.—Section 1886(d)(10)(D)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(v)), as it relates to a reclassification being effective for 3 fiscal years, shall not apply with respect to reclassifications made under this section.

(c) PROCESS FOR APPLICATIONS TO ENSURE THAT PROVISIONS APPLY BEGINNING OCTOBER 1, 2003.—The Secretary shall establish a process for the Medicare Geographic Classification Review Board to accept, and make determinations with respect to, applications that are filed by applicable hospitals within 90 days of the date of enactment of this section to reclassify based on the provisions of this section in order to ensure that such provisions shall apply to payments under such section 1886(d) for discharges occurring on or after October 1, 2003.

(d) ADJUSTMENTS TO ENSURE BUDGET NEUTRALITY.—If 1 or more applicable hospital's applications are approved pursuant to the process under subsection (c), the Secretary shall make a proportional adjustment in the standardized amounts determined under paragraph (3) of such section 1886(d) for payments for discharges occurring in fiscal year 2004 to ensure that approval of such applications does not result in aggregate payments under such section 1886(d) that are greater or less than those that would otherwise be made if this section had not been enacted.

AMENDMENT NO. 1019

Mr. CONRAD. Mr. President, the first amendment would provide immediate prescription assistance to certain chronically ill beneficiaries. We have a very curious circumstance. Under current law, Medicare Part B covers injectable drugs if they are routinely administered by a physician in the office. However, if a similar drug is available that could be self-injected at home, it is not covered.

That makes no sense at all. This policy causes a significant burden for seniors with certain illnesses such as multiple sclerosis, rheumatoid arthritis, and other diseases. This amendment would address this problem by providing immediate coverage of drugs that could be administered at home when they are used to replace drugs that are covered when given in a physician's office. This transitional benefit would expire when a comprehensive Medicare drug benefit is implemented in 2006.

I am proud to say I am working on this effort with Senator MURRAY of Washington, who has introduced similar legislation in bill form; Senator SMITH, who is also on the Finance Committee, who has been a leading advocate of this approach; Senator LINCOLN; and Senator JEFFORDS. It is supported by more than 40 patient organizations.

This is a common-sense policy which provides real and immediate help to thousands of America's seniors. It is entirely paid for by codifying that Medicare is the secondary payer when beneficiaries have other private insurers that provide them with coverage.

I hope my colleagues will look with favor on this amendment.

AMENDMENT NO. 1020

The second amendment would address payment inequity that has hurt America's rural hospitals. As many know, rural health care providers are often forced to operate with significantly less resources than larger urban facilities. In my State of North Dakota, rural hospitals often receive only one-half the reimbursement their urban counterparts get for treating the exact same illness.

For example, a rural facility in North Dakota receives approximately $4,200 for treating pneumonia, while a hospital in New York receives more than $8,500 to treat that same illness. The funding disparity is simply unfair and has placed many rural providers on shaky ground.

To address this situation, MedPAC has recommended various policies, including equalizing the standard payment amount, which has been 1.6 percent higher for urban facilities. There is no policy basis for this difference.

Earlier this year the omnibus appropriations bill took steps to equalize the standardized amount but only until the end of fiscal year 2003. This amendment finishes the job by making this change permanent.

Again, this amendment is fully paid for by the legislation codifying that Medicare is the secondary payer when beneficiaries have alternative coverage.

AMENDMENT NO. 1021

Finally, I am offering a third amendment that would address a disparity related to whether certain hospitals are eligible to be reclassified for the purposes of the in-patient hospital wage index.

Under current law, hospitals have to meet certain mileage or proximity requirements in order to reclassify to the wage index value applied to another area of the State. In rural States such as North Dakota, this restriction has produced unfair, certainly unintended, consequences.

In my State, there are hospitals on the western side of North Dakota which are hundreds of miles from the eastern side of the State but compete for the same labor pool—compete for the same doctors, the same nurses—and have the same costs. However, because of this mileage restriction, they are not able to get paid the same. In fact, there is an 18-percent difference in the wage index between hospitals in Bismarck, ND, and hospitals in Fargo, ND—an 18-percent difference. It makes no earthly sense.

North Dakota hospitals have tried to address this situation by appealing to CMS on various occasions, to no avail. And the reason it has been to no avail is because the law says you have to be contiguous. Well, there is a 200-mile difference between Bismarck and Fargo, but they are in contiguous markets. They compete for the same doctors, the same nurses, and they need to be treated in the same way.

This amendment would address this situation by allowing certain hospitals in my State to reclassify to another area of the State for purposes of the wage index. This change would be budget neutral.

I urge my colleagues to support these three important amendments.

Let me just say, if I can, to my colleagues, I am also working on a fourth amendment, the dialysis annual update formula. I am working on that with Senator SANTORUM and the chairman and ranking member. We are hopeful of being able to work out that amendment at a later point.

Mr. President, these are the amendments I am seeking to have considered.

AMENDMENT NO. 1019

Mr. SMITH. Mr. President, I rise today with my colleague from North Dakota in support of critical drug coverage for beneficiaries who contend with the debilitating effects of Multiple Sclerosis. This amendment would provide transitional coverage for the four FDA-approved therapies in the 2-year interim until 2006, when the prescription drug plan will take effect.

Approximately 400,000 Americans have MS. In my home State of Oregon, it is estimated that there are 5,800 people living with MS. Currently, Medicare covers only one of the four FDA-approved MS therapies and only when administered by a physician.

This amendment would cover all four MS therapies, including when they are administered by the patients themselves, providing better coverage and better care for Americans with Multiple Sclerosis. While these therapies do not cure MS, they can slow its course, and have provided great benefit to MS patients.

It is critical that MS patients have access to all approved drugs because some MS patients do not respond well to, or cannot tolerate, the one MS therapy that is currently covered. Currently, many Medicare beneficiaries with MS are forced to take the less effective therapy, to pay the costs out of pocket, or forgo treatment.

Equally, this amendment is important to rural Medicare beneficiaries with MS. By administering drugs themselves, rural beneficiaries can avoid the costs and hassles of traveling long distances to health care facilities to receive their MS therapy.

In the spirit of providing all Medicare beneficiaries with increased choice, MS patients need and deserve the full range of treatment choices currently available and self-administration helps ensure access to needed medications. I urge my colleagues on both sides of the aisle to join me in support of this amendment and to provide adequate and comprehensive drug coverage for MS patients.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, with the graciousness of the Senator from New York, I ask unanimous consent that the Senator from Washington be recognized for up to 3 minutes to speak on one of the amendments offered by the Senator from North Dakota.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mrs. MURRAY. Mr. President, I thank my colleague from New York.

AMENDMENT NO. 1019

Mr. President, I have a statement I will give for the RECORD, but I also want to thank Senator CONRAD for his work on the self-injected biologics and the offering of this amendment tonight. I am delighted to be a cosponsor on this amendment. It is something I have worked on for over 2 years. And as Senator CONRAD said, we have patients today with MS, with rheumatoid arthritis, who are forced to go to a doctor, a medical clinic in order to get the drugs they need.

This will save us money in the long run because people will be able to stay home. But, most importantly, it will allow people quality of life in the care they need. I thank Senator CONRAD and Senator SMITH and the other cosponsors of this amendment.

Mr. President, I am pleased to join with Senator CONRAD and Senator SMITH in offering this amendment to give those on Medicare access to a new, exciting group of drugs known as self-injected biologics.

Senator CONRAD offered a similar amendment during the Senate Finance Committee markup and received a commitment from the chair to work with us on this effort.

As a result of this commitment, Senator CONRAD withdrew the amendment. We have been working with CBO and Senator BAUCUS' staff to address any concerns.

Currently, Medicare will only cover biologics if they are administered in a physician's office or clinical setting. That means patients must travel to the physician's office to receive treatment. This is not easy for many patients who have rheumatoid arthritis or MS—two diseases that can severely limit a person's mobility.

Fortunately, there are versions of these drugs that a patient can take in their own home. It is a great innovation that will improve a patient's access.

Unfortunately, Medicare won't cover biologics that are administered in the home. That just doesn't make sense. I have been working to correct this inequity for the past 2 Congresses.

The Murray-Conrad-Smith amendment would provide 2 years of coverage, under Part B, for those self-injected biologics that replace treatments currently available only in a physician's office.

We allow for 2-year coverage to bridge the gap to implementation of a Medicare prescription drug benefit.

We have received a CBO score for the 2 years and believe that we can find room in 2004 and 2005 to provide this important coverage for MS and RA patients.

This legislation is strongly endorsed by the Arthritis Foundation and will provide additional coverage to all four MS self-injected or self-administered treatments.

For MS, only one treatment is covered under Medicare, provided in a physician's office.

I am hopeful that the managers of this legislation will be able to accept our amendment and end this discriminatory practice in Medicare.

Mr. President, I thank the Senator from New York.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. CONRAD. Mr. President, I appreciate very much the leadership Senator MURRAY has provided on this issue. I really took her legislation and, because I am a member of the Finance Committee, I had an opportunity to offer it. But I want to make clear, this is a bill Senator MURRAY introduced. I was proud to pick it up in the Finance Committee so it could be offered at the appropriate time there.

I thank her for her leadership. I think we are close to getting this accomplished. It will be a great tribute to the Senator from Washington and the legislative leadership she has provided.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. Mr. President, I join with my colleague from North Dakota in thanking the Senator from Washington for championing this cause for so long because it is clearly long overdue. And I thank both Senators for presenting it to us in this context. I look forward to supporting it.

Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside so I may offer several amendments.

The PRESIDING OFFICER. That authority has already been granted.

AMENDMENTS NOS. 1000 AND 999

Mrs. CLINTON. Mr. President, I rise today to speak of four amendments I have filed. And I would like to discuss each in turn, starting with amendment No. 1000, offered on behalf of myself, Senator TIM JOHNSON, and Senator——

The PRESIDING OFFICER. If the Senator will suspend for a moment, we are trying to find the amendments here at the desk.

The clerk will report the amendments that are at the desk.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON], for herself, Mr. JOHNSON, and Mr. BINGAMAN, proposes an amendment numbered 1000.

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 999.

The amendments are as follows:

AMENDMENT NO. 1000

(Purpose: To study the comparative effectiveness and safety of important Medicare covered drugs to ensure that consumers can make meaningful comparisons about the quality and efficacy)

At the end of title VI, add the following:

SEC. ___. STUDY ON EFFECTIVENESS OF CERTAIN PRESCRIPTION DRUGS.

(a) IN GENERAL.—

(1) RESEARCH BY NIH.—The Director of the National Institutes of Health, in coordination with the Director of the Agency for Healthcare Research and Quality and the Commissioner of Food and Drugs, shall conduct research, which may include clinical research, to develop valid scientific evidence regarding the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(2) ANALYSIS BY AHRQ.—

(A) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, taking into consideration the research and data from the National Institutes of Health and the Food and Drug Administration, shall use evidence-based practice centers to synthesize available data or conduct other analyses of the comparative effectiveness and, where appropriate, comparative safety of covered prescription drugs relative to other drugs and treatments for the same disease or condition.

(B) SAFETY.—In any analysis of comparative effectiveness under this subparagraph, the Director of the Agency for Healthcare Research and Quality shall include a discussion of available information on relative safety.

(3) STANDARDS.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Commissioner of Food and Drugs, the Director of the National Institutes of Health, and with input from stakeholders, shall develop standards for the design and conduct of studies under this subsection.

(b) COVERED PRESCRIPTION DRUGS.—For purposes of this section, the term ''covered prescription drugs'' means prescription drugs that, as determined by the Director of the Agency for Healthcare Research and Quality in consultation with the Administrator of the Centers for Medicare & Medicaid Services, account for high levels of expenditures, high levels of use, or high levels of risk to individuals in federally funded health programs, including Medicare and Medicaid.

(c) DISSEMINATION.—

(1) ANNUAL REPORT.—Each year the Secretary shall prepare a report on the results of the research, studies, and analyses conducted by the National Institutes of Health and the Agency for Healthcare Research and Quality, and the Food and Drug Administration under this section and submit the report to the following:

(A) Congress.

(B) The Secretary of Defense.

(C) The Secretary of Veterans Affairs.

(D) The Administrator of the Centers for Medicare & Medicaid Services.

(E) The Director of the Indian Health Service.

(F) The Director of the National Institutes of Health.

(G) The Director of the Office of Personnel Management.

(H) The Commissioner of Food and Drugs.

(2) REPORTS FOR PRACTITIONERS.—As soon as possible, but not later than a year after the completion of any study pursuant to subsection (a)(2), the Director of the Agency for Healthcare Research and Quality shall—

(A) prepare a report on the results of such study for the purpose of informing health care practitioners; and

(B) transmit the report to the Director of the National Institutes of Health.

(3) FDA DRUG INFORMATION.—The Commissioner of Food and Drugs shall—

(A) review all data and information from studies and analyses conducted or prepared under this section; and

(B) develop appropriate summaries of such information for inclusion in adequate directions for use under section 502(f)(1) of the Federal Food, Drug, and Cosmetic Act and in summaries relating to side effects, contraindications, and effectiveness under section 502(n) of that Act.

(4) NIH INTERNET SITE.—The Director of the National Institutes of Health shall publish on the Institutes' Internet site and through other means that will facilitate access by practitioners, each report prepared under this subsection by the Director of the Agency for Healthcare Research and Quality.

(d) EVIDENCE.—In carrying out this section, the Director of the National Institutes of Health and the Agency for Healthcare Research and Quality shall consider only methodologically sound studies, giving preference to studies for which the Directors have access to sufficient underlying data and analysis to address any significant concerns about methodology or the reliability of data.

(e) AUTHORIZATIONS OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $75,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

AMENDMENT NO. 999

(Purpose: To provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level)

On page 389, between lines 6 and 7, insert the following:

SEC. ___. PRIORITY AREA QUALITY INDICATORS.

(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Quality Interagency Coordination Task Force, the Institute of Medicine, the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, the American Health Quality Association, the National Quality Forum, and other individuals and organizations determined appropriate by the Secretary of Health and Human Services, shall assemble, evaluate, and, where necessary, develop or update quality indicators for each of the 20 priority areas for improvement in health care quality as identified by the Institute of Medicine in their report entitled ''Priority Areas for National Action'' in 2003, in order to assist medicare beneficiaries in making informed choices about health plans. The selection of appropriate quality indicators under this subsection shall include the evaluation criteria formulated by clinical professionals, consumers, data collection experts.

(b) RISK ADJUSTMENT.—In developing the quality indicators under subsection (a), the Director of the Agency for Healthcare Research and Quality shall ensure that adequate risk adjustment is provided for.

(c) BEST PRACTICES.—In carrying out this section, the Director of the Agency for Healthcare Research and Quality shall—

(1) assess data concerning appropriate clinical treatments based on the best scientific evidence available;

(2) determine areas in which there is insufficient evidence to determine best practices; and

(3) compare existing quality indicators to best clinical practices, validate appropriate indicators, and report on areas where additional research is needed before indicators can be developed.

(d) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Director of the National Institutes of Health a report concerning areas of clinical care requiring farther research necessary to establish effective clinical treatments that will serve as a basis for quality indicators; and

(2) submit to Congress a report on the state of quality measurement for priority areas that links data to the report submitted under paragraph (1) for the year involved.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $12,000,000 for fiscal year 2004, and $8,000,000 for each of fiscal years 2005 through 2009.

SEC. ___. STANDARDIZED QUALITY INDICATORS FOR FEDERAL AGENCIES.

(a) IN GENERAL.—In addition to other activities to be carried out by the Quality Interagency Coordination Taskforce (as established by executive order on March 13, 1998), such Taskforce shall standardize indicators of health care quality that are used in all Federal agencies, as appropriate.

(b) CONSULTATION.—In carrying out subsection (a), the Quality Interagency Coordination Taskforce shall consult with a public-private consensus organization (such as the National Quality Forum) to enhance the likelihood of the simultaneous application of the standardized indicators under subsection (a) in the private sector.

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the progress made by the Quality Interagency Coordination Taskforce to standardizing quality indicators throughout the Federal Government.

SEC. ___. DEMONSTRATION PROGRAM FOR COMMUNITY HEALTH CARE QUALITY DATA REPORTING.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Quality and Research, shall award not to exceed 20 grants to eligible communities for the establishment of demonstration programs for the reporting of health care quality information at the community level.

(b) QUALITY INDICATORS.—

(1) IN GENERAL.—For purposes of reporting information under the demonstration programs under this section, indicators of health care quality may include the indicators developed for the 20 priority areas as identified by the Institute of Medicine in the report entitled ''Priority Areas for National Action'', 2003, or other indicators determined appropriate by the Secretary of Health and Human Services.

(2) TYPE OF DATA.—All quality indicators with respect to which reporting will be carried out under the demonstration program shall be reported by race, ethnicity, gender, and age.

(c) ELIGIBILITY.—The Secretary of Health and Human Services shall award grants to communities under this section based on competitive proposals and criteria to be determined jointly by the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality. Such criteria may include a demonstrated ability of the community to collect data on quality indicators and a demonstrated ability to effectively transmit community-level health status results to relevant stakeholders.

(d) TECHNICAL ADVISORY COMMITTEE.—The Secretary of Health and Human Services shall establish a technical advisory committee to assist grantees in data collection, data analysis, and report dissemination.

(e) REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Director of the Centers for Disease Control and Prevention and the Director of the Agency for Healthcare Research and Quality shall—

(1) submit to the Congress a report on the results of the demonstration programs under this section; and

(2) make such reports publicly available, including by posting the reports on the Internet.

(f) EVALUATION.—The Secretary of Health and Human Services shall, upon awarding grants under subsection (a), enter into a contract for the evaluation of demonstration programs under this section. Such evaluation shall compare the effectiveness of such demonstration programs in collecting and reporting required data, and on the effectiveness of distributing information to key stakeholders in a timely fashion. Such evaluations shall provide for a report on best practices.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $25,000,000 for fiscal year 2004, and such sums as may be necessary for each fiscal year thereafter.

The PRESIDING OFFICER. The Senator from New York.

Mrs. CLINTON. Thank you, Mr. President.

AMENDMENT NO. 1000

Mr. President, amendment 1000, offered on behalf of myself and Senators TIM JOHNSON and JEFF BINGAMAN, is being offered to ensure our seniors have information they need to make informed consumer choices about their drugs, and also to ensure practitioners have the information needed to choose the right drug for a patient, and, further, that the private plans this bill would create have the information they need to make formulary and benefit design choices based on sound science.

This amendment ensures that various Government agencies—NIH, FDA, CMS, and the others involved in this effort—conduct research comparing the efficacy and, if applicable, the comparative safety of the top drugs used by Medicare and Medicaid beneficiaries who are Medicare eligible.

Now often there are a number of competing drugs to treat the same condition. But which is more effective? Oftentimes we just do not know.

While the FDA is responsible for determining safety and effectiveness of prescription drugs compared to a placebo, there is no Government entity responsible for examining whether drug A is more effective at treating a particular condition than drug B. Meanwhile, drug companies do not always have an incentive to do head-to-head trials of the drugs they put out versus those of their competitors. But this information is critical to all decisionmakers, to patients and consumers, to practitioners, and to the private plans that are being created.

Now clinicians have told me they are frequently trying to decide whether to switch a patient from an old drug to a new drug. They are not deciding between the old drug and a placebo; they are deciding between a drug they have used for a particular patient and then one which has come to their attention because it is now on the market, and they are trying to decide: Which is best for my patient? They wish they had more information that would enable them, besides trial and error and possible adverse consequences, to make that determination.

Clearly, consumers will also benefit from more sources of information. Right now advertising is a source available to consumers, but this amendment will help us provide an unbiased, scientific source of information that consumers can compare side by side rather than just a beautiful advertisement of people running through a field or twirling their grandchildren and then being told: This is the drug for the condition you have. They will be able to say: Well, wait a minute. Here is the drug I have been prescribed, here is a drug I have heard about. Let me look on the Internet to see what the differences might be.

Now we have all heard of ''me too'' drugs, and there is nothing wrong with ''me too'' drugs. Sometimes a ''me too'' drug will work incrementally better than a previous drug or it may be better tolerated. Even if a ''me too'' drug does not have those characteristics, it might be superior for a certain portion of the population but not for others. The problem is, we do not have that kind of comparative data.

My amendment directs NIH to do comparative efficacy trials for the top Medicare drugs—the ones that are primarily prescribed for the Medicare population—for the kinds of conditions the Medicare population primarily suffers from.

No single study will settle that question once and for all, so my amendment then directs the Agency for Health Research and Quality, AHRQ, to do what it does best, which is to synthesize the literature that is out there as well as the NIH data to report information on the comparative efficacy of these medical interventions that we are subsidizing now in this bill for our seniors.

HHS will then make this comparative information available to clinicians, to Congress, to relevant Federal agencies. And it will, most particularly and importantly, make that available to seniors so they can make informed choices for themselves.

Under this amendment, we would put this information on the Internet. FDA would look at whether this information needs to be included in drug labels, and drug ads would also contain this information so that they do not mislead seniors.

One indicator of the rarity of these studies is that completion of a comparative efficacy study can make national news. For example, many of us

read last December when the National Heart, Lung, and Blood Institute published a study and discovered that it corrected the assumption that newer drugs, such as calcium channel blockers and ACE inhibitors, which cost 30 to 40 times more than diuretics, were not more effective than those long-time treatments for high blood pressure. This is information we have needed for years. We have one of the most advanced health care systems, if not the most advanced, in the world. If the information stream our doctors count is such a tiny trickle that the daily news can keep track of all major developments, then this amendment must be passed in order to give us a sound scientific basis for the decisions that are going to be made with the $400 billion that we are allocating.

When the research is done, as we learned about in the calcium channel blockers and ACE inhibitors versus old-fashioned diuretics, it is important and its benefits are immediately obvious.

In January 2003, the American Journal of Ophthalmology published an article comparing the efficacy of two glaucoma drugs. One is latanoprost and the other bimatoprost. These were compared in an NIH-sponsored randomized clinical trial. Despite the fact that the Latanoprost is currently the most popular medication, the study found that Bimatoprost was more effective.

This is critically important because if we are going to be putting money into drugs and we are going to be holding out the promise to our seniors that finally help is on the way, then let's make sure these tax dollars are used to fund the drugs that are most effective.

In 1999, an NIH-sponsored study showed that a well-known, safe, cheap generic drug, Metoprolol, was just as effective for treating patients with heart failure as a more expensive drug which had come on to the market just a few years earlier. Some may say these studies could promote a one-size-fits-all approach to prescribing, but to the contrary, these studies can actually help make prescribing more nuanced and appropriate to each subpopulation.

For instance, in March 2003, the American Journal of Cardiology reviewed numerous clinical trials of medications used to treat what is called atrial fibrillation, a type of heart arrhythmia, and came up with recommendations about what are the most effective drugs for use for this condition based on what the underlying cause of the condition was in each case.

As someone who is fast approaching the age of Medicare eligibility, I want, both for my pocketbook and my health, to know that my doctor and I have the best information available about which drug is appropriate for me. And I certainly think that we can, through this amendment, begin to provide that information to ensure that seniors and their physicians have good, solid data on which to make their decisions.

This amendment is supported by a number of groups that are aware of the significance of trying to put into this bill some scientifically based data on which to make these decisions. The RxHealth Value Coalition is supporting the amendment. I have a letter from them. They consist of not only large employers—Verizon, General Motors, Ford, et cetera—but Blue Cross, Blue Shield, Kaiser, AARP, and many others.

I ask unanimous consent to print the RxHealth Value letter of June 24, 2003, supporting this amendment, in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

RXHEALTHVALUE,
Washington, DC, June 24, 2003.

Hon. HILLARY RODHAM CLINTON,
U.S. Senate,
Russell Senate Office Building,
Washington, DC.

DEAR SENATOR CLINTON: As the 108th Congress considers reforming the Medicare program and addressing one of the programs major shortcomings—lack of an outpatient prescription drug benefit, we want to express support for your amendment to the Medicare legislation being considered by the Senate that would provide limited support for the Centers of Medicare and Medicaid Services, the Center for Medicare Choices, which would be created by S. 1, the National Institutes of Health and the Agency for Healthcare Research and Quality to collaborate on studies to compare the relative efficacy and safety of prescription medicines designed to treat the same condition. It is this very information that is vital to patients, practitioners, and purchasers. With comparative information on prescription medicines patients, practitioners and purchasers can make better decisions with respect to choosing the prescription medicines to take, prescribe, cover, and pay for.

RxHealthValue is a national coalition of large employers, consumer groups, labor unions, health plans, health care providers and pharmacy benefit managers that, through its members, represents almost 100 million Americans. RxHealthValue is committed to research, education and both public- and private-sector solutions to ensure that Americans receive the full health and economic value from their prescription drugs. The Coalition's definition of ''value'' includes effectiveness, cost, appropriate use and safety.

Your amendment is a very important component of any Medicare prescription drug benefit proposal, since it is imperative that the federal Centers for Medicare & Medicaid Services (CMS) and the proposed Center for Medicare Choices (CMC) have the needed information to be a prudent purchaser of prescription drugs. We are pleased that you ask the National Institutes of Health (NIH) to add to the very limited research results from which evidence-based reviews get their information, and that you recognized the importance of dissemination so that information gets to providers and consumers when they need it. We agree that AHRQ's Evidence-based Practice Centers (EPCs), which have been involved in the innovative Oregon prescription drug program, would be an outstanding vehicle for such reviews.

This legislation is especially important as Congress works to provide Medicare beneficiaries with high quality outpatient drug coverage. We applaud your efforts on this important amendment and look forward to working with you and others to ensure that improved information on prescription drugs is available to all.

For more information on RxHealth's position on this and other drug value initiatives, please contact Steve Cole, RxHealthValue Policy Committee Chair, at 202–296–1314.

Again, thank you from the member organizations of RxHealthValue:

Blue Cross/Blue Shield.
Kaiser.
AARP.
National Consumers League.
Verizon.
Association of Community Health Plans.
General Motors.
Ford.
Daimler Chrysler.
Families USA.
National Organization of Rare Disorders.
American Academy of Family Physicians.
Academy of Managed Care Pharmacy.
UAW.
AFSCME.
Pacific Business Group on Health.
Midwest Business Group on Health.
Washington Business Group on Health.
Advance–PCS.
Caremark Rx.
AFL–CIO.

Mrs. CLINTON. Similarly, I have a letter from Consumers Union, dated June 24, 2003, which also supports amendment No. 1000, and I ask unanimous consent that letter, too, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONSUMERS UNION,
June 24, 2003.

Hon. TIM JOHNSON,
U.S. Senate,
Washington, DC.

DEAR SENATOR JOHNSON: Consumers Union strongly supports your amendment that would provide for study by the National Institute of Health and the Agency for Healthcare Research and Quality of the comparative effectiveness of prescription drugs. The development of scientific evidence-based information about the relative effectiveness of drugs has the potential to dramatically increase consumers' (and taxpayers') bang-for-the-buck paid for prescription drugs.

Millions of Medicare beneficiaries (in addition to the tens of millions of uninsured and underinsured consumers nationwide) are paying increasing out-of-pocket costs for their prescription drugs. Despite these escalating costs, it is often difficult for consumers and health care professionals to ensure that consumers receive value for each healthcare dollar spent.

The proposed amendment would create a resource for independent information about the comparative medical effectiveness of important medicines. We believe that this information will substantially reduce the nation's prescription drug expenditures, because consumers and doctors will be able to make decisions using reliable evidence-based information about comparative effectiveness. The amendment would require this information to be made available through the Internet to the public. As a result, consumers, employers, state governments and the federal government will have access to information that will enable them to choose more cost-effective medicines without sacrificing medical effectiveness or quality of care.

Sincerely,

GAIL E. SHEARER,
Director, Health Policy Analysis,
Washington Office.

Mrs. CLINTON. Finally, I have a letter from Families USA, dated June 24, 2003, that similarly supports the amendment. I will read the following paragraph from it:

It would be unfortunate if Congress decides to spend $400 billion on pharmaceuticals over the next decade, without providing a few dollars to ensure that what we are buying is indeed worth buying.

I ask unanimous consent that letter be printed in the RECORD as well.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FAMILIES USA,
June 24, 2003.

HON. HILLARY RODHAM CLINTON,
U.S. Senate,
Washington, DC.

DEAR SENATOR CLINTON: Congratulations on your amendment to help Americans understand which prescription drugs are truly effective and safe. Families USA, the national health consumer advocacy organization, strongly endorses the effort of you and Senator Johnson to provide reliable, unbiased information on pharmaceuticals.

Too often today, prescription drug information is influenced by the manufacturer, by advertisements, and by clinical studies financed by those who will gain from favorable reports. Americans need an objective, reliable source of information on which prescription drugs are most effective.

It would be unfortunate if Congress decides to spend $400 billion on pharmaceuticals over the next decade, without providing a few dollars to ensure that what we are buying is indeed worth buying.

Thank you again for you leadership on this important health consumer initiative.

Sincerely,

RONALD F. POLLACK,
Executive Director.

Mrs. CLINTON. Mr. President, if we are serious about making changes that will improve the health of our seniors on Medicare, I hope that we look to establish in this bill the proposition that good information, solid science that can be made available to seniors, to clinicians, to plans, be part of what we are establishing with the proposition that this money needs to be well spent, well spent not only to safeguard the taxpayers' dollars but well spent to ensure that our doctors and patients get the best possible treatment.

I also am offering amendment No. 999 that is intended to ensure that Medicare plans compete to improve rather than cut corners on quality. This bill already includes a measure that I have supported, along with Senator HATCH and others, to commission the Institute of Medicine to ensure the Medicare Program pays plans for providing higher quality care.

Unfortunately, even for the many common diagnoses and treatments that are part of a senior's medical history, we lack the quality standards that the Medicaid Program would use to help consumers make informed comparisons and choices among health plans.

For some diseases, the National Commission for Quality Assurance does collect information about health plans by providing data, for example, on how well HMOs screen for breast cancer or provide flu shots for older adults.

For many other diseases, however, we do not know which plans make sure that their diabetic patients get their eyes examined for retinal damage, what percent of asthmatics receive adequate therapy to control their asthma, or many other issues that go to the heart of the quality of health care that is being provided to our seniors.

The data tells us that Medicare beneficiaries are often not receiving the care they need to maintain their health. In 2001, for example, 23 percent of Medicare beneficiaries in private health plans did not have their cholesterol managed after a heart attack.

Now, my amendment is based on recommendations made by the Institute of Medicine. It authorizes a collaborative effort among the relevant Government agencies to develop quality indicators in the 20 most important areas identified in this Institute of Medicine report entitled ''Priority Areas for National Action.'' It authorizes the Quality Interagency Coordination Task Force—that is a task force that brings together all the Federal agencies that are needed to collect health quality data—to implement these indicators so that they are all collecting quality information in the same way. The Secretary of Health and Human Services would then develop demonstration programs for communities to engage in community-wide reporting, according to these quality indicators.

This amendment also has the potential to lower the cost of the Medicare Program. Because plans will provide quality measures that consumers will use, health plans will want to implement those quality improvement measures that have also been proven to lower health care costs. One such program, as an example, is a diabetes intervention program implemented by Group Health Cooperative, a group model health plan in Washington State. This intervention program improved diabetic blood sugar control and saved between $685 and $950 annually from reduced hospital admissions, emergency department visits, and physician consultations.

This is the kind of emphasis on quality that I think we need to put into this bill. Otherwise, as we try to make sense of the variety of options and choices that are available, we are not going to know what improved quality or what decreases costs. That should be one of our goals, and this amendment holds out the promise that the Medicare Program, with proper implementation of quality indicators, can do both—improve health and quality control and decrease costs.

AMENDMENT NO. 953

Mrs. CLINTON. Mr. President, I will also be talking about amendment No. 953, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 953.

Mrs. CLINTON. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide training to long-term care ombudsman)

On page 608, between lines 10 and 11, insert the following:

SEC. ___. TRAINING FOR LONG-TERM CARE OMBUDSMAN.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of the Administration on Aging and in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall authorize a program, to be developed and implemented by the National Long-Term Care Ombudsman Resource Center, for the training of long-term care ombudsmen in the use of quality of care information.

(b) TRAINING.—Under the program developed under subsection (a), training shall be provided to long-term care ombudsman to enable such ombudsman to educate consumers concerning—

(1) nursing home quality of care issues;

(2) available nursing home quality of care reports, including existing quality data that the Administrator of the Centers for Medicare & Medicaid Services has released for use by the public in choosing long-term care facilities; and

(3) the manner in which an individual can successfully integrate quality information into health care decision making regarding nursing home decisions.

(c) DUTIES OF RESOURCE CENTER.—The National Long-Term Care Ombudsman Resource Center shall—

(1) develop and maintain a curriculum for ombudsmen;

(2) develop, produce, and maintain training materials;

(3) conduct train-the-trainer programs at regional and national levels; and

(4) act as a clearinghouse for best practices in communicating the significance of nursing home quality indicators to residents and their caregivers.

(d) PILOT PROGRAMS.—The Secretary of Health and Human Services shall award grants for the establishment of 1-year pilot demonstration programs in 10 States using long-term care ombudsmen to educate consumers regarding home health care quality. Such pilot demonstration programs shall test the effectiveness of having a committed position within the State dedicated to helping consumers use home health care quality indicators.

(e) REPORT.—Not later than 18 months after the date of enactment of this Act, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report concerning the effectiveness of the program established under this section, including the benefits of providing for dedicated staff who are responsible for educating consumers to use home health quality indicators in their health care decision-making.

(f) AUTHORIZATION.—In addition to any other amounts authorized to be appropriate for long-term care ombudsman programs, there are authorized to be appropriated to carry out this section $4,000,000 for fiscal year 2004 (of which $1,000,000 shall be used to carry out subsection (d)), and $2,000,000 for each fiscal year thereafter.

Mrs. CLINTON. Mr. President, amendment No. 953 would empower Medicare beneficiaries and their families in making decisions about nursing

homes and home health services. Data on nursing home quality is publicly available through a project strongly supported by Administrator Scully, and I am very appreciative of that because that information is imperative.

However, I know from talking with people throughout New York that there are still many problems in nursing homes with respect to errors and mishaps that undermine the quality of care, the quality of life and, in some respects, even the health of the nursing home residents. Many people still don't know about this existing quality data and about the existing ombudsman program within the administration on aging that is intended to help families navigate nursing home decisions.

This amendment would establish a national long-term care ombudsman resource center, which will help to develop and train ombudsmen. The amendment would establish pilot programs, including grants to create ombudsman offices in 10 States. These are the people—it should really be ''ombudspeople,'' I guess—who are uniquely positioned to know about the facilities they serve. They visit the facilities regularly. They are often located at agencies in the local communities. They have firsthand knowledge. They are very valuable resources. However, their knowledge, if it doesn't actually get to the users, the nursing home residents and, more importantly, their family members or advocates, doesn't help anyone.

This pilot project would fund specific ombudsman programs to provide comprehensive outreach, public education, and individual consultation that integrate quality information into health care decisionmaking. Through this pilot project, the ombudsman center would be able to identify the resources needed to actually provide consumer education on long-term care and home health, as well as best practices and collaborative models that could then be replicated around the country.

I ask my colleagues also to support this amendment because, again, I think information is critical. We talk about trying to create more of a market for these health care resources. Markets exist on information. A market without good information is not really a market at all. So if we are going to move toward the private market and provide these private health plans as competition to the existing Medicare delivery system, then I think we have to do more than just talk about the market. We need to empower the consumers within the marketplace. Information is that basis for empowerment.

AMENDMENT NO. 954

Mrs. CLINTON. Mr. President, I ask the clerk to report amendment No. 954, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New York [Mrs. CLINTON] proposes an amendment numbered 954.

Mrs. CLINTON. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information)

On page 46, between lines 13 and 14, insert the following:

''(i) HEALTH LITERACY STANDARDS.—

''(1) IN GENERAL.—For purposes of assisting eligible entities in providing quality assurance measures as described in subsection (c)(1)(B), the Secretary, acting through the Director of the Agency for Healthcare Research and Quality, the Administrator of Health Resources and Services Administration, the Director of the National Library of Medicine, and the Commissioner of Food and Drugs, shall develop standardized materials that pharmacists may use to assist non-English speaking or functionally illiterate patients in the safe and appropriate use of prescription drugs. Such materials may include the use of pictures and the development of standardized translations in multiple languages of prescription labels and bottle labels and other patient safety initiative information. Such materials shall be available electronically for direct access by pharmacists.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2004 and 2005.

Mrs. CLINTON. Mr. President, this amendment is intended to improve the safety of the prescription drug program. As our seniors are using a growing number of medications to stay out of the hospital, to live healthier and longer lives, we are inadvertently, but inevitably, creating a burden on our seniors to understand and know how to use all of these prescription drugs. There are interactions, there are other issues, there are many problems with trying to sort out for our seniors how drugs work, how they interact with one another. This is a very important issue that I think, again, we need to address at the beginning of this process, not after some additional problems have been discovered.

In a recent study of adverse drug events published in the Journal of the American Medical Association, 21 percent of preventable adverse drug events were caused by patients not following drug prescription instructions. That is just human nature. People make mistakes and, as you get older, it is harder to read all that little writing on the prescription bottles. That is something that just kind of comes with the process. Of course, we have many people for whom English is not their first language. We have others who have challenges with eyesight and literacy. So, clearly, our seniors, like the rest of us, could make mistakes.

Studies have found that one-third of patients often don't take the prescription the way they are supposed to because they don't understand it. Now, if you have a dose of a three-times-a-day antibiotic, and you also have other prescription drugs to be taken five, six, seven times a day, or whatever the combination is, there are all kinds of opportunities for confusion because many seniors take complex drugs with multiple dangerous side effects, often much more serious than those from antibiotics. They are more likely to suffer injuries and hospitalizations as a result. As many as 60 percent of the elderly have these problems about understanding and following the directions. This is a very critical statistic. Twenty-three percent of nursing home admissions in our country result from the inability of older Americans to manage their medication at home.

That is why I am offering this amendment to ensure that the Secretary of HHS works to ensure the use of health literacy standards and information that will minimize adverse drug events, to ensure that we develop drug informational materials for non-English-speaking people and the functionally illiterate patients that can be made available to pharmacists who can access them electronically for easy use.

So, Mr. President, these amendments can be summed up in a very few words: enhanced quality, lower cost.

If we enhance quality, we avoid a lot of the problems that exist in our system today. We learn more about quality. We empower patients, as well as clinicians, with information that can better determine quality outcomes, and we save money. We do not have people being admitted to the hospital because they mix up their drugs. We do not have people trying to figure out how they can get good information about quality standards in nursing homes. We have all kinds of issues that cost money, as well as put the health and well-being of our seniors at risk.

I ask that my colleagues favorably consider these amendments. There is no cost attached to these amendments, but they will do what we hope to achieve by this significant legislation: improve quality for our seniors and lower costs in the long run by making prescription drugs readily available and understanding appropriately their use.

Mr. President, I thank you for your kind attention, and I yield the floor.

AMENDMENT NO. 1000

Mr. JOHNSON. Mr. President, I join my colleagues Senators CLINTON and BINGAMAN today to offer an amendment to S. 1 that will provide consumers and practitioners with real, objective information regarding the comparative effectiveness of prescription drugs.

Too often, prescription drug information is influenced by drug manufacturers, through advertisements, and by clinical studies financed by those who will gain from favorable reports. Consumers are just inundated with information—from direct-to-consumer advertising on drugs which can paint a misleading picture, to a sea of free

drug samples from their physicians—with all this information it can be extremely difficult to make a sound decision which can be just overwhelming for average Americans.

But what does the data really say about differing prescription drug options? Does a newer drug that costs more than an earlier version necessarily do a better job for most patients? Is it possible that a Medicare beneficiary may get the same, or even better outcome from the drug that has been on the market for a longer time? We just really don't have the answers to these—questions at least from independent, objective sources.

We are about to create a massive new program that will effect 40 million Americans and with this comes responsibility to deliver a program that ensures the availability of appropriate prescription drugs for all beneficiaries. This amendment will create a reliable source for valid, evidence-based information about the comparative medical effectiveness of medicines used by Medicare beneficiaries. It will provide unbiased information on how drugs that treat particular diseases and conditions compare to one another.

By authorizing the National Institutes of Health, in coordination with the Agency for Healthcare Research and Quality to conduct research on comparative effectiveness of drugs, consumers, employers, State governments and the Federal Government will finally have access to information that will enable them to choose medicines based on clinical research. This information will be made available to help them make better decisions with respect to choosing the prescription medicines to take, prescribe, cover and pay for. By using the objective, scientific expertise available at NIH and AHRQ, this amendment assures that the information received comes from independent and impartial sources.

This amendment is supported by RxHealthValue, a national coalition of large employers, consumer groups, labor unions, health plans, health providers and pharmacy benefit managers that through its members represent almost one-hundred million Americans. It is also supported by Families USA and Consumers Union.

This amendment preserves individuals' freedom to get any medicine that they want, but would encourage the use of medicines that are scientifically proven more effective for patients. It will not create ''one-size-fits-all'' medicine as Republicans will try and tell you. It does nothing to prevent independent decisionmaking by practitioners and their patients, just better educated decisionmaking.

Our Republican colleagues believe in the strength of the free market. Well, a well functioning marketplace depends on the free flow of information. Denying consumers and providers, as well as other purchasers of prescription drugs access to comparative information about effectiveness means that decisions in the marketplace are made without perfect information—which should not be the case in an open market. You are not going to buy a car without taking a look at Consumer Reports are you? Are you only going to base your purchase on the glitzy adds in ''Car and Driver'' magazine? I think we all know the answer to this is ''no'', and most certainly Medicare beneficiaries should have access to similar information for drugs they put in their bodies as they do for the car they drive.

AMENDMENT NO. 985, AS MODIFIED

Mr. REID. Mr. President, on behalf of Senator EDWARDS of North Carolina, I send a modification to the desk, and I ask unanimous consent the amendment be so modified.

The PRESIDING OFFICER. Without objection, it is so ordered. The amendment will be so modified.

The amendment (No. 985), as modified, is as follows:

At the end, add the following:

TITLE ___—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following ''(including, if the Secretary so requires, whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)''; and

(2) in subsection (d)(5)—

(A) by inserting ''(A)'' after ''will''; and

(B) by inserting after ''thereof'' the following: ''or (B), if the Secretary has required information related to comparative safety and effectiveness, offer a benefit with respect to safety or effectiveness (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug''.

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after ''effectiveness'' the following: ''(including effectiveness in comparison to other drugs for substantially the same condition or conditions if such comparative information is available)''.

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions if such comparative information is available);

(ii) information relating to side effects and contraindications; and

(B) any advertisement present a fair balance comparable in depth, between—

(i) aural and visual presentations relating to effectiveness of the drug; and

(ii) aural and visual representations relating to side effects and contraindications, provided that, nothing in this section shall require explicit images or sounds depicting side effects and contraindications;

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow

any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

AMENDMENT NO. 1036

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator BOXER. This is an amendment to eliminate the coverage gap for individuals with cancer.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mrs. BOXER, proposes an amendment numbered 1036.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To eliminate the coverage gap for individuals with cancer)

On page 53, between line 8 and 9, insert the following:

''(6) NO COVERAGE GAP FOR ELIGIBLE BENEFICIARIES WITH CANCER.—

''(A) IN GENERAL.—In the case of an eligible beneficiary with cancer, the following rules shall apply:

''(i) Paragraph (2) shall be applied by substituting 'up to the annual out-of-pocket limit under paragraph (4)' for 'up to the initial coverage limit under paragraph (3)'.

''(ii) The Administrator shall not apply paragraph (3), subsection (d)(1)(C), or paragraph (1)(D), (2)(D), or (3)(A)(iv) of section 1860D–19(a).

''(B) PROCEDURES.—The Administrator shall establish procedures to carry out this paragraph. Such procedures shall provide for the adjustment of payments to eligible entities under section 1860D–16 that are necessary because of the rules under subparagraph (A).''

AMENDMENT NO. 1037

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Mr. CORZINE. This is a technical amendment regarding federally qualified health centers.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. CORZINE, proposes an amendment numbered 1037.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To permit medicare beneficiaries to use Federally qualified health centers to fill their prescriptions)

At the end of subtitle A of title I, add the following:

SEC. ___. CONFORMING CHANGES REGARDING FEDERALLY QUALIFIED HEALTH CENTERS.

(a) PERMITTING FQHCS TO FILL PRESCRIPTIONS.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(1) in subparagraph (A), by striking ''and'' after the comma at the end;

(2) in subparagraph (B), by inserting ''and'' after the comma at the end; and

(3) by adding at the end the following new subparagraph:

''(C) drugs and biologicals for which payment may otherwise be made under this title,''.

(b) ELIMINATION OF PER VISIT LIMIT.—Section 1833(a)(3) (42 U.S.C. 1395l(a)(3)) is amended by inserting '', except that such regulations may not limit the per visit payment amount with regard to drugs and biologicals described in section 1861(aa)(3)(C)'' after ''the Secretary may prescribe in regulations''.

AMENDMENT NO. 1038

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator JEFFORDS dealing with critical access to hospitals.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. JEFFORDS, proposes an amendment numbered 1038.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To improve the critical access hospital program)

At the end of section 405 add the following:

(g) EXCLUSION OF CERTAIN BEDS FROM BED COUNT AND REMOVAL OF BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS.—

(1) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—Section 1820(c)(2) (42 U.S.C. 1395i-4(c)(2)) is amended by adding at the end the following:

''(E) EXCLUSION OF CERTAIN BEDS FROM BED COUNT.—In determining the number of beds of a facility for purposes of applying the bed limitations referred to in subparagraph (B)(iii) and subsection (f), the Secretary shall not take into account any bed of a distinct part psychiatric or rehabilitation unit (described in the matter following clause (v) of section 1886(d)(1)(B)) of the facility, except that the total number of beds that are not taken into account pursuant to this subparagraph with respect to a facility shall not exceed 25.''.

(2) REMOVING BARRIERS TO ESTABLISHMENT OF DISTINCT PART UNITS BY CRITICAL ACCESS HOSPITALS.—Section 1886(d)(1)(B) (42 U.S.C. 195ww(d)(1)(B)) is amended by striking ''a distinct part of the hospital (as defined by the Secretary)'' in the matter following cause (v) and inserting ''a distinct part (as defined by the Secretary) of the hospital or of a critical access hospital''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to determinations with respect to distinct part unit status, and with respect to designations, that are made on or after October 1, 2003.

AMENDMENT NO. 1039

Mr. REID. Mr. President, I ask unanimous consent that the pending amendments be set aside, and I send an amendment to the desk on behalf of Senator INOUYE dealing with Native Hawaiians.

The PRESIDING OFFICER. Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. INOUYE, proposes an amendment numbered 1039.

Mr. REID. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system)

At the appropriate place, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Native Hawaiian Medicaid Coverage Act of 2003''.

SEC. 2. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN THROUGH A FEDERALLY-QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) MEDICAID.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended, in the third sentence, by inserting '', and with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) through a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement between a Federally-qualified health center or a Native Hawaiian health care system and another health care provider'' before the period.

(b) EFFECTIVE DATE.—The amendment made by this section applies to medical assistance provided on or after the date of enactment of this Act.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, I ask unanimous consent that the pending amendments be set aside so that I may speak on my amendment No. 1011.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1011

Mr. SESSIONS. Mr. President, the bill we are moving forward today is a prescription drug bill, a Medicare reform bill. It is not a welfare reform bill. Unfortunately, through the process, as it often happens when legislation moves through this body, the Finance Committee, without having hearings, faced an amendment that came up and it became a part of the bill that is on the Senate floor today. It would provide benefits not to American citizens but to non-citizens. It

would amend the law that was passed some time ago prohibiting such actions.

So I have sent to the desk an amendment which would strike section 605 of the bill, the section that allows Medicaid and State health insurance program coverage to be given to noncitizens, and insert a sense of the Senate that this section should be referred back to the Finance Committee.

In 1996, with a vote of 74 to 24, this body made a principled, purposeful decision during reform of welfare in this country, that non-citizens should not access Federal programs such as TANF and Medicaid for the first 5 years they are in the United States. That is because these costs are supposed to be incurred by the sponsors of those people who come into the United States. That is why we make the sponsor of an immigrant who comes into the United States lawfully sign an affidavit that they will be responsible for that person's health care benefit. Of those Senators who are still in service in this body, 45 voted for it. That is quite a significant number.

Section 605 would lift the 5-year ban for pregnant women, and children, from fiscal year 2005 through fiscal year 2007. In other words, we would allow pregnant women and children who have sponsors in the United States to access the welfare system of America to pay for their health care, contrary to the fully debated and wisely established rule in 1996 not to do that.

The President is concerned about that. The administration is opposed to this change. They note that the administration has proposed substantial new flexibility on the part of Medicaid and SCHIP reform, and coverage for legal immigrants should be examined as part of this context.

So we will be examining Medicaid, the SCHIP program, and Medicare reform later this year. That is the time we should be discussing changing our current policy as to what benefits are available to noncitizens, not slipping it through as part of this important bill.

This is not a decision that we should change, not a policy that ought to be altered, without some significant study and debate. We are amending the welfare reform bill as part of a prescription drug bill. This is a major policy shift. It ought not to be added in this fashion. This bill is for America's senior citizens, not for non-citizens. If we want to make such important changes in funding eligibility and criteria for these programs, we ought to be ready to have a full and open debate on welfare policy. That is the kind of debate we had in 1996. I think some good decisions were made then that helped this country tremendously. It helped poor families move from welfare to work and did a lot of things for children in this country.

The Finance Committee, which added section 605, should have hearings and go about it as part of the welfare reform bill. I feel strongly about that.

Before 1996, the cost of welfare for immigrants had skyrocketed in America to $8 billion a year. That was in 1996. Harvard economist George Borjas found that immigrant households were 50 percent more likely to use Federal welfare programs than were citizen households. So this was the untenable position and situation in 1996, and that is what was ended by the legislation then.

In 1996, Congress dealt specifically with the issue of welfare and immigration. In an overwhelming manner they passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 which was signed by President Clinton and became law.

The 1996 welfare and immigration reforms significantly restricted participation of new immigrants in Federal means-tested poverty programs and dramatically curtailed the access of permanent resident aliens to Federal welfare programs. That was exactly our goal. The 1996 reform strengthened the welfare system and made more funds available for citizens in need. In passing this law in 1996, this Senate specifically stated certain national policy concerns related to welfare and immigration that should not be changed haphazardly.

They said self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration status. Self-sufficiency is a key part of our whole concept of immigration.

It continues to be the immigration policy of the United States that:

(A) Aliens within the Nation's borders not depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations, and the availability of public benefits not constitute an incentive for immigration to the United States.

Despite the principle of self-sufficiency, aliens have been applying for and receiving public benefits from Federal, State, and local governments at increasing rates.

It is a compelling government interest to enact new rules for eligibility and sponsorship agreements in order to assure that aliens be self-reliant in accordance with national immigration policy.

It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.

That is what we are talking about. That sums it up. That was a thoughtful policy and change made in 1996. We ought not to have it slip through here on this important bill today without full hearings and discussion.

Section 605, which now in this bill, would repeal the general prohibition of nonqualified aliens being eligible for any Federal public benefits, as it applies to protect women and children, even though ample exceptions for certain public benefits are already provided, such as emergency medical assistance. That is available now. Short-term disaster relief. Immunization, housing, and communities development assistance, and any assistance specified by the Attorney General.

Section 605 waives the 5-year waiting period before immigrants are allowed to receive Federal benefits, thus creating a huge incentive for the benefited class of citizens to rush the borders for instant care. A person who has the possibility of coming to this country, has considered it and decided not to, if their child has a health problem, would not they, therefore, be incentivized to try to come across this border, knowing they could apply for and have public benefit of the United States?

And we would like to do that. Do we do that for the entire world? It is just not possible. It is not good public policy. A nation has to have policy that is rational and defensible.

A wide range of Federal programs are exempted from this requirement, including emergency Medicaid, certain immunizations, short-term disaster relief, school lunch programs, the WIC program, foster care, adoptive assistance, and Head Start. Those are available now.

Section 605 will dissolve the financial accountability requirement of the sponsor. If section 605 passes, sponsors will no longer be held responsible to the Government for the cost of the Federal means-tested benefits to the aliens they sponsor.

The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, coupled with the 1996 welfare reform law, purposefully altered the obligations of persons whose sponsored immigrants arrived or are adjusting status in the United States.

In 1996, as part of the immigration reform, we required that affidavit of support be rewritten as a legally binding contract, enforceable against the sponsor through the time the sponsor immigrant becomes a citizen or has contributed to Social Security for 10 years. Affidavits of support are intended to implement the provisions of the INA that excludes aliens who appear ''likely at any time to become a public charge.'' No nation accepts people into their country who are likely to be a public charge of the country. A nation accepts people who are going to be contributors and will benefit that society.

This is consistent with the recommendation of the Commission on Immigration Reform. In a report to Congress the commission stated sponsors of immigrants should be held financially responsible for the immigrants they bring into this country.

Under the INA code a sponsor is defined as a person who is a citizen, national or lawfully admitted, of the United States, 18 years of age, lives in the United States and demonstrates the means to financially maintain a sponsorship. They can petition the Federal Government through an affidavit of support for the admittance of an individual residing outside the United States.

In other words, a sponsor has to be a person who has the means to financially maintain a sponsorship. If they

cannot sign that affidavit honestly, then the person should not be admitted into the country. The sponsor requirement allows for the admission of any person into the United States who is unable to take care of himself or herself without becoming a charge to the taxpayers by assuring, via affidavit, that the sponsor will financially support the person.

An affidavit for support may not be accepted unless the sponsor agrees to, one, provide financial support to maintain the sponsored alien; two, be legally bound to the Federal Government of any entity that provides any means-tested public benefit which includes Medicaid; and three, submit to the jurisdiction of any Federal court.

If a sponsored alien received any means-tested public benefits, the entity which provided such benefits can request to be reimbursed by the sponsor, and if reimbursement is not satisfied, then the sponsor will face civil penalty.

Under this proposed legislation, the sponsors of these new immigrants would be absolved from their liability under the program. Aliens will no longer be supported and maintained by their sponsors and would become a charge on the public once again, a problem we sought to and did remedy in 1996.

As we finish here tonight, we have a lot of important matters involved in this legislation, involving a lot of money. CBO estimates that this provision would cost half a billion over three years. It spends that money by changing what I think to be a good policy by creating a bad policy, a policy that will incentivize people to come to the United States for free health care when they may not otherwise wish to come or may not otherwise benefit from coming here. We really have not had the kind of debate, as a comprehensive review of welfare, that should be made a part of that.

The Finance Committee will be considering welfare reform. It will be considering these issues in the months to come. They have a lot on their plate.

This amendment simply says let's not rush this through now. Let's not move it through on this important bill that is going to move through Congress. Let's send it back to the Finance Committee. Let's encourage them to give thoughtful and serious concern to it. Let's have them come forward with a program that would justify us changing this important rule, established in 1996.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

MEXICAN BARRIERS TO IMPORTS OF U.S. AGRICULTURAL PRODUCTS

Mr. GRASSLEY. Mr. President, it has been almost 10 years since the North American Free Trade Agreement—NAFTA—went into effect. Overall, this agreement has been a great success for America's farmers and ranchers. Between 1994 and 2002, U.S. Agricultural exports to Mexico grew by 95 percent.

Mexican agriculture has benefited as well from NAFTA. Exports of Mexican agricultural products to the United States increased by almost 97 percent from 1993 to 2001. At the present time, some 78 percent of all agricultural products exported by Mexico are sent to the United States, making the United States by far the largest market for Mexico's agricultural exports. Clearly, the agricultural sectors of both the United States and Mexico have on the whole profited from NAFTA. For this reason, I am confounded by some of the recent actions of the Mexican government that undermine the spirit, if not the letter, of NAFTA.

Allow me to elaborate on some of these actions. Mexico has recently imposed, or threatened to impose, trade barriers to a wide variety of U.S. agricultural products. These products include pork, beef, corn, high fructose corn syrup, rice, apples, and dry beans. Apparently ignoring that increased competition in the Mexican market has benefited that country's consumers, some in Mexico have spoken of renegotiating the agriculture provisions of the NAFTA. Mexico's measures against U.S. agricultural products have certainly caught the attention of many members of the Senate, including me.

Let me explain Mexico's actions that are directly impacting producers in my state of Iowa.

I'll start with high fructose corn syrup. It's true that U.S. producers of agricultural products have, on the whole, benefited from NAFTA. And, at one point, that was the case with U.S. producers of high fructose corn syrup. Mexico was formerly the largest export market for U.S. produced high fructose corn syrup. But in January 2002, the Mexican Congress imposed a tax of up to 20 percent on soft drinks containing high fructose corn syrup.

This move was undoubtedly intended to provide Mexican sugar producers with an unfair advantage in the Mexican market over U.S. high fructose corn syrup producers. As a result of this discriminatory tax, U.S. exports of high fructose corn syrup to Mexico are now at almost zero levels.

Mexico's high fructose corn syrup tax was imposed following WTO and NAFTA panel rulings that found that a 1998 Mexican antidumping order on U.S. high fructose corn syrup did not comply with Mexico's trade obligations.

Clearly, Mexico is going out of its way to prevent the sale of high fructose corn syrup in its market. Mexico's high fructose corn syrup tax is causing great harm to U.S. corn producers and U.S. high fructose corn syrup manufacturers. The U.S. corn refining industry estimates that it is losing up to $620 million annually on account of Mexico's discriminatory tax. It estimates that U.S. corn farmers are losing over $300 million each year due to lost sales to both U.S. and Mexican high fructose corn syrup producers.

I find it especially ironic that Mexico, a country that is actively seeking foreign investment, is treating so poorly the U.S. high fructose corn syrup industry, an industry that has invested heavily in Mexico.

Based upon the promises of NAFTA, U.S. high fructose corn syrup producers made major investments in the United States and Mexico. Mexico has now pulled the rug out from under them. This certainly sends, at best, mixed signals to foreign investors.

Let me give you another example of Mexico's actions against U.S. agricultural products, this one impacting Iowa's pork producers. In January of this year, Mexico initiated an antidumping investigation on U.S.-produced pork. The petition that initiated this investigation has serious deficiencies. for example, the petition was filed by Mexican hog producers, not pork processors, so it is my understanding that the party bringing the case lacks standing under the Antidumping Agreement of the WTO.

While Mexico's antidumping investigation on pork is ongoing, I recognize that Mexican officials last month terminated the Mexican antidumping order on imports of live hogs from the United States. I am pleased with Mexico's decision regarding the live hog order. I strongly hope that this decision provides an indication that Mexican officials will act reasonably and not impose an antidumping order on U.S. pork.

But there are other problems. Large quantities of U.S.-produced pork have been rejected at the Mexican borer during the past year due to alleged sanitary problems. But millions of Americans consume U.S.-produced pork each day, and we know that this product is safe. Mexico's rejection of U.S. pork for non-scientific reasons violates Mexico's WTO obligations.

Iowa's beef producers are also being harmed by Mexico's actions. In April 2000, Mexico imposed antidumping duties on imports of U.S. beef, and this trade measure remains in place. Mexico's investigation resulted in numerous probable violations of Mexico's commitments under the WTO Agreements. On June 16, the U.S. Trade Representative announced that the United States is filing a case at the WTO over Mexico's antidumping order. I fully support the U.S. trade Representatives's actions at the WTO regarding this matter.

Despite the ongoing Mexican antidumping order on U.S. beef, Mexican cattle producers earlier this year filed a safeguard petition on beef from the United States.

Mexican officials have neither confirmed nor denied the existence of this petition. Lack of certainty with regard to this safeguard petition has made it even more difficult for the U.S. cattle and beef industry to plan sales in Mexico.